2022
COMMUNITY HEALTH NEEDS ASSESSMENT

Chelan, Douglas, Grant & Okanogan Counties, Washington

Sponsored by
Confluence Health

Confluence HEALTH

THREE RIVERS HOSPITAL

2021-1474-02

Prepared by PRC

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Confluence Health (Central Washington Hospital and Wenatchee Valley Hospital). Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Confluence Health by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for comparison to benchmark data at the state and national levels.

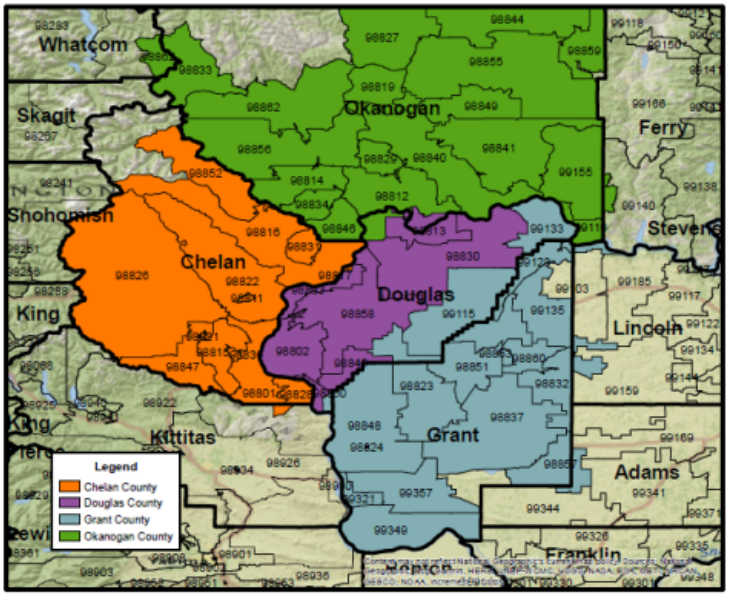
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Confluence Health and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Total Service Area" in this report) includes each of the residential ZIP Codes comprising Chelan, Douglas, Grant, and Okanogan counties in Washington. This community definition, determined based on the ZIP Codes of residence of recent patients of Confluence Health, is illustrated in the following map.

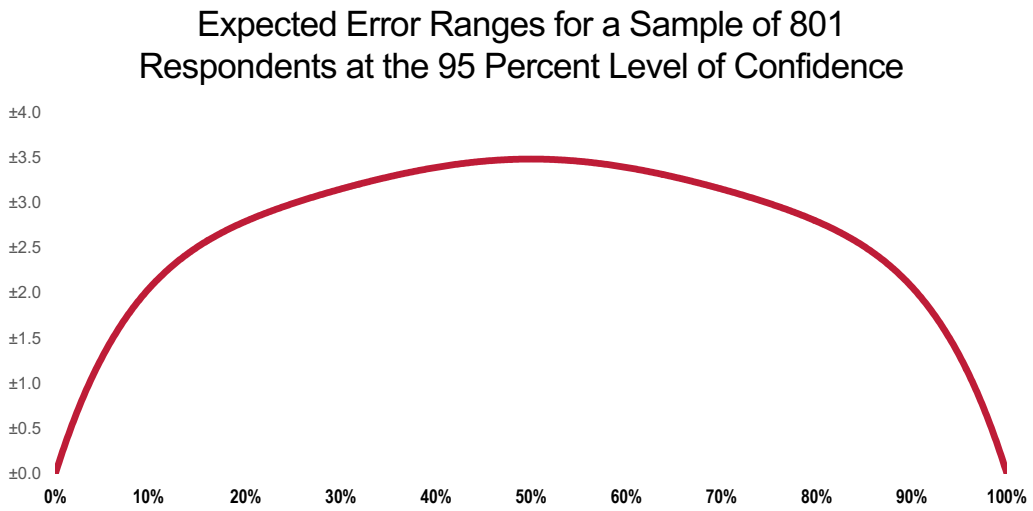


Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology – one that incorporates both landline and cell phone interviews – was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a stratified random sample of 801 individuals age 18 and older in the Total Service Area, including 250 in Chelan County, 101 in Douglas County, 300 in Grant County, and 150 in Okanogan County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Total Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 801 respondents is ±3.5% at the 95 percent confidence level.



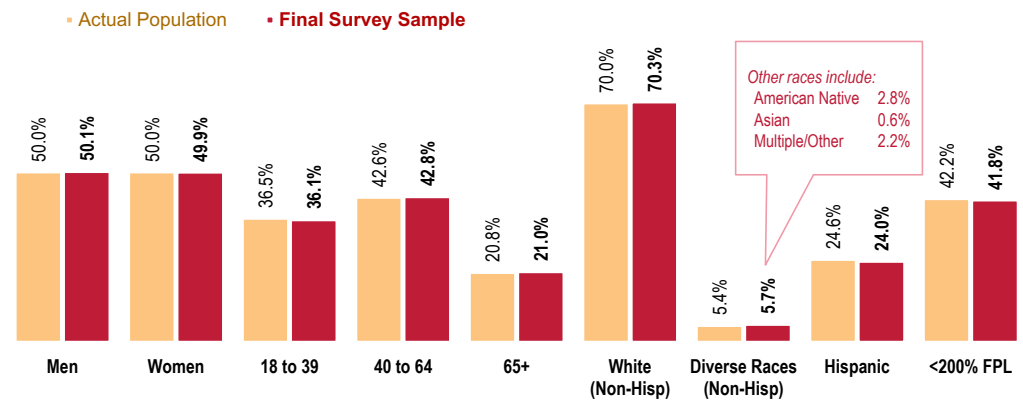
Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 801 respondents answered a certain question with a "yes," it can be asserted that between 7.9% and 12.1% (10% ± 2.1%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.5% and 53.5% (50% ± 3.5%) of the total population would respond "yes" if asked this question.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents. The following chart outlines the characteristics of the Total Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's health care needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(Total Service Area, 2022)



Sources:
- US Census Bureau, 2011-2015 American Community Survey.
- 2022 PRC Community Health Survey, PRC, Inc.

Notes:
- FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

INCOME & RACE/ETHNICITY

INCOME ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2021 guidelines place the poverty threshold for a family of four at $26,500 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Confluence Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 63 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	1
Public Health Representatives	1
Other Health Providers	6
Social Services/Nonprofit Representatives	19
Community/Business Leaders	36

Final participation included representatives of the organizations outlined below.

- Aging and Adult Care
- Alatheia Riding Center
- Americagroup
- American Heart Association
- America Red Cross–Apple Valley Chapter
- Apple Valley Honda
- Ballard Ambulance
- Big Bend Community College
- Cascade Medical Center
- Cascade Medical Foundation
- Cascade School District
- Chelan County
- Chelan County PUD
- Chelan Douglas Casa
- Chelan Douglas Regional Port Authority
- Chelan Douglas Transportation Council
- City of Cashmere
- City of Chelan
- City of East Wenatchee
- City of Leavenworth
- City of Waterville
- City of Wenatchee
- Columbia Basin Allied Arts
- Columbia Basin Hospital
- Colville Tribal Police Department
- Confluence Health
- Confluence Health Foundation
- EASE Cancer Foundation
- East Wenatchee Police Department
- Epilepsy Foundation
- Foundation for Youth Resiliency and Engagement
- Grand Coulee School District
- Grant County
- Jeffers Danielson Sonn & Aylward
- John L. Scott Real Estate
- KC–Help
- Laura Mounter Real Estate
- Manson School District
- Mid Valley Hospital
- Molina Healthcare
- Moses Lake Community Health Center
- Moses Lake Police Department
- NCW Nurses Week
- NCW Tech Alliance

- North Central ACH
- North Central Educational Service District
- Okanogan Behavioral HealthCare
- Okanogan County
- Okanogan County Community Action
- Okanogan County Health District
- Okanogan County Sheriff's Office
- Okanogan County Transit
- Okanogan Regional Humane
- Okanogan School District
- Omak School District
- Orondo School District
- Our Valley Our Future
- Pateros Brewster Community Resource Center
- Pateros School District
- People for People
- Port of Quincy
- Rick Pankow Foundation
- SAGE
- Star Ranch
- The Economic Alliance
- Tierra Village
- Together for Youth
- Washington Apple Education Foundation
- Washington State Tree Fruit Association
- Washington State University Extension
- Waterville School District
- Wenatchee Downtown Association
- Wenatchee Police Department
- Wenatchee Valley College
- Wenatchee Valley YMCA
- YWCA

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.
In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.
NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Total Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)

- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Data

Washington Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives – and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.

- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups – such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish – are not represented in the survey data. Other population groups – for example, pregnant women, lesbian/gay/bisexual/ transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups – might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Confluence Health made its prior Community Health Needs Assessment (CHNA) report publicly available through its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Confluence Health had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Confluence Health will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	7
Part V Section B Line 3b Demographics of the community	36
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	183
Part V Section B Line 3d How data was obtained	7
Part V Section B Line 3e The significant health needs of the community	17
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	17
Part V Section B Line 3h The process for consulting with persons representing the community's interests	10

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	189

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Appointment Availability – Finding a Physician ▪ Routine Medical Care (Adults) ▪ Eye Exams ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death
DIABETES	▪ Blood Sugar Testing [Non-Diabetics]
HEART DISEASE & STROKE	▪ Leading Cause of Death
INFANT HEALTH & FAMILY PLANNING	▪ Teen Births
MENTAL HEALTH	▪ Suicide (Age-Adjusted Death Rates) ▪ Symptoms of Chronic Depression ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Overweight & Obesity [Adults] ▪ Overweight & Obesity [Children]
POTENTIALLY DISABLING CONDITIONS	▪ High-Impact Chronic Pain ▪ Alzheimer's Disease Deaths
SUBSTANCE ABUSE	▪ Cirrhosis/Liver Disease Deaths ▪ Use of Prescription Opioids ▪ Personally Impacted by Substance Abuse (Self or Other's) ▪ Key Informants: Substance abuse ranked as a top concern.

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Substance Abuse
3. Nutrition, Physical Activity & Weight
4. Diabetes
5. Heart Disease & Stroke
6. Cancer
7. Access to Healthcare Services
8. Infant Health & Family Planning
9. Potentially Disabling Conditions

Hospital Implementation Strategy

Confluence Health will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables:
Comparisons With Benchmark Data

Reading the Summary Tables

- In the following tables, Total Service Area results are shown in the larger, gray column.
- The columns to the left of the Total Service Area column provide comparisons among the four counties, identifying differences for each as "better than" (B), "worse than" (h), or "similar to" (≃) the combined opposing counties.
- The columns to the right of the Total Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Total Service Area compares favorably (B), unfavorably (h), or comparably (≃) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	B 5.0	6.7	h 9.1	B 3.8	6.6	h 3.8	h 4.3	
Population in Poverty (Percent)	11.7	11.6	14.8	h 19.5	14.1	h 10.8	13.4	h 8.0
Children in Poverty (Percent)	17.1	B 15.9	20.3	h 26.8	19.7	h 13.6	18.5	h 8.0
No High School Diploma (Age 25+, Percent)	17.4	17.9	h 23.3	16.1	19.3	h 8.7	h 12.0	
% Unable to Pay Cash for a $400 Emergency Expense	17.0	17.3	18.3	h 25.3	18.9		B 24.6	
% Worry/Stress Over Rent/Mortgage in Past Year	20.2	B 12.9	h 23.8	18.1	19.9		B 32.2	
% Unhealthy/Unsafe Housing Conditions	8.5	B 2.4	7.9	8.3	7.3		B 12.2	
% Food Insecure	15.4	13.8	h 25.3	16.2	18.7		B 34.1	
	Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.					B better	similar	h worse

OVERALL HEALTH	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
% "Fair/Poor" Overall Health	17.1	22.8	21.7	14.7	19.2	h 16.2	h 12.6	
	Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.					B better	similar	h worse

ACCESS TO HEALTH CARE	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
% [Age 18-64] Lack Health Insurance	7.1	5.3	10.4	7.0	8.0	B 11.9	8.7	7.9
% Difficulty Accessing Health Care in Past Year (Composite)	43.9	33.8	40.7	48.7	42.1		h 35.0	
% Cost Prevented Physician Visit in Past Year	9.2	5.2	5.7	7.6	7.0	B 11.5	B 12.9	
% Cost Prevented Getting Prescription in Past Year	4.1	4.2	5.3	4.9	4.7		B 12.8	
% Difficulty Getting Appointment in Past Year	28.2	B 19.0	28.6	h 35.1	28.1		h 14.5	
% Inconvenient Hrs Prevented Dr Visit in Past Year	11.1	5.4	7.3	12.1	9.1		B 12.5	
% Difficulty Finding Physician in Past Year	17.4	22.7	B 13.8	h 25.2	18.3		h 9.4	
% Transportation Hindered Dr Visit in Past Year	8.1	4.6	B 5.0	h 12.8	7.3		8.9	
% Language/Culture Prevented Care in Past Year	0.4	0.9	0.6	B 0.0	0.5		B 2.8	
% Skipped Prescription Doses to Save Costs	8.8	5.5	7.9	12.2	8.6		B 12.7	
% Difficulty Getting Child's Health Care in Past Year					7.4		8.0	
Primary Care Doctors per 100,000	B 172.0	B 109.3	h 70.6	h 41.9	102.6	115.2	102.3	

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
% Have a Specific Source of Ongoing Care	74.0	h 64.3	B 81.4	B 89.0	77.6		74.2	h 84.0
% Have Had Routine Checkup in Past Year	61.2	55.9	64.5	B 70.9	63.2	h 71.5	h 70.5	
% Child Has Had Checkup in Past Year					88.9		B 77.4	
% Likely to Use Telemedicine	42.4	h 29.0	36.1	42.5	38.2			
% Two or More ER Visits in Past Year	6.7	h 16.9	6.6	11.5	9.0		10.1	
% Eye Exam in Past 2 Years	49.7	51.1	48.1	49.1	49.2		h 61.0	h 61.1
% Rate Local Health Care "Fair/Poor"	B 12.1	19.0	B 11.2	h 29.2	15.9		h 8.0	
						B better	similar	h worse

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

CANCER	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
Cancer (Age-Adjusted Death Rate)	142.6	130.8	148.9	167.5	148.0	142.5	146.5	h 122.7
Lung Cancer (Age-Adjusted Death Rate)					32.4	30.0	33.4	h 25.1
Prostate Cancer (Age-Adjusted Death Rate)					18.4			

						19.8	18.5	16.9
	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
CANCER	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
Female Breast Cancer (Age-Adjusted Death Rate)					22.3	☁ 19.1	☁ 19.4	h 15.3
Colorectal Cancer (Age-Adjusted Death Rate)					12.3	☁ 11.8	☁ 13.1	h 8.9
Cancer Incidence Rate (All Sites)	☁ 469.0	☁ 447.5	☁ 421.2	☁ 457.9	448.1	☁ 442.4	☁ 448.6	
Female Breast Cancer Incidence Rate	☁ 131.9	☁ 117.7	☁ 113.5	☁ 124.7	122.2	☁ 133.5	☁ 126.8	
Prostate Cancer Incidence Rate	☁ 120.2	☁ 114.1	☁ 96.6	☁ 105.9	108.9	☁ 98.1	☁ 106.2	
Lung Cancer Incidence Rate	☁ 51.7	☁ 54.1	☁ 55.8	☁ 59.5	55.0	☁ 52.7	☁ 57.3	
Colorectal Cancer Incidence Rate	☁ 38.9	B 33.6	☁ 38.7	☁ 41.0	38.4	☁ 35.1	☁ 38.0	
% Cancer	☁ 11.0	☁ 10.3	☁ 9.3	☁ 10.8	10.3	☁ 12.4	☁ 10.0	
% [Women 50-74] Mammogram in Past 2 Years					71.9	☁ 75.1	☁ 76.1	☁ 77.1
% [Age 50-75] Colorectal Cancer Screening	☁ 77.9	B 92.0	☁ 74.7	☁ 77.9	79.1	B 72.1	☁ 77.4	B 74.4
						B	☁	h

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that

data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DIABETES	DISPARITY AMONG COUNTIES: Chelan County	Douglas County	Grant County	Okanogan County	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
Diabetes (Age-Adjusted Death Rate)	19.8	B 15.8	23.6	h 36.0	23.5	21.2	22.6	
% Diabetes/High Blood Sugar	13.3	11.2	12.2	14.4	12.8	h 9.4	13.8	
% Borderline/Pre-Diabetes	8.1	8.1	9.5	6.5	8.3		9.7	
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	32.7	33.1	38.0	B 44.7	36.7		h 43.3	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

B better ☁ similar h worse

HEART DISEASE & STROKE	DISPARITY AMONG COUNTIES: Chelan County	Douglas County	Grant County	Okanogan County	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
Diseases of the Heart (Age-Adjusted Death Rate)	130.9	B 118.3	155.5	144.8	139.8	134.9	B 164.4	127.4
% Heart Disease (Heart Attack, Angina, Coronary Disease)	5.5	12.7	B 4.8	11.0	7.4	5.6	6.1	
Stroke (Age-Adjusted Death Rate)	B 29.0	B 29.8	h 40.0	40.7	35.0	34.6	37.6	33.4
% Stroke	3.6	B 0.3	4.3	3.6	3.3	2.9	4.3	
% Told Have High Blood Pressure					36.6	h		h

	34.8	41.7	35.5	37.5		30.3	36.9	27.7

	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
HEART DISEASE & STROKE (continued)	**Chelan County**	**Douglas County**	**Grant County**	**Okanogan County**		**vs. WA**	**vs. US**	**vs. HP2030**
% Told Have High Cholesterol	26.1	28.6	26.6	34.4	**28.1**		B 32.7	
% 1+ Cardiovascular Risk Factor	82.6	h 91.3	86.5	82.3	**85.3**		84.6	
						B better	similar	h worse

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
INFANT HEALTH & FAMILY PLANNING	**Chelan County**	**Douglas County**	**Grant County**	**Okanogan County**		**vs. WA**	**vs. US**	**vs. HP2030**
Low Birthweight Births (Percent)	6.1	5.7	6.1	7.0	**6.2**	6.5	B 8.2	
Infant Death Rate					**4.0**	4.3	B 5.5	B 5.0
Births to Adolescents Age 15 to 19 (Rate per 1,000)	B 23.5	B 23.3	h 35.9	h 37.0	**30.5**	h 16.3	h 20.9	
						B better	similar	h worse

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
INJURY & VIOLENCE	**Chelan County**	**Douglas County**	**Grant County**	**Okanogan County**		**vs. WA**	**vs. US**	**vs. HP2030**
Unintentional Injury (Age-Adjusted Death Rate)	43.5	B 34.3	48.8	h 64.8	**47.8**	45.6	51.6	43.2

INJURY & VIOLENCE (continued)	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
Motor Vehicle Crashes (Age-Adjusted Death Rate)			15.9	16.5	11.8	h 8.0	11.4	10.1
[65+] Falls (Age-Adjusted Death Rate)					63.9	B 91.7	67.0	63.4
Firearm-Related Deaths (Age-Adjusted Death Rate)	B 11.3		13.5	h 19.8	13.0	h 10.7	12.5	h 10.7
Homicide (Age-Adjusted Death Rate)	B 3.1		4.3	5.0	3.9	h 3.3	B 5.9	B 5.5
Violent Crime Rate	B 144.6	B 102.6	h 277.9	h 287.8	211.1	B 297.1	B 416.0	
% Victim of Violent Crime in Past 5 Years	1.2	B 0.0	B 0.3	h 6.0	1.6		B 6.2	
% Victim of Intimate Partner Violence	14.1	B 9.1	14.2	h 20.9	14.6		13.7	
	Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.					B better	similar	h worse

KIDNEY DISEASE	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
Kidney Disease (Age-Adjusted Death Rate)					3.0	B 4.6	B 12.8	
% Kidney Disease	3.8	3.3	2.9	5.0	3.6	2.7	5.0	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

B better ☁ similar h worse

DISPARITY AMONG COUNTIES | TOTAL SERVICE AREA vs. BENCHMARKS

MENTAL HEALTH	Chelan County	Douglas County	Grant County	Okanogan County	Total Service Area	vs. WA	vs. US	vs. HP2030
% "Fair/Poor" Mental Health	☁ 15.2	B 3.7	☁ 17.9	h 21.7	15.5		☁ 13.4	
% Diagnosed Depression	☁ 26.0	B 17.4	☁ 25.3	☁ 25.8	24.4	☁ 24.2	☁ 20.6	
% Symptoms of Chronic Depression (2+ Years)	☁ 41.7	B 26.6	☁ 38.0	☁ 35.5	37.0		h 30.3	
% Typical Day Is "Extremely/Very" Stressful	h 13.2	B 1.7	☁ 9.3	☁ 7.5	9.0		B 16.1	
Suicide (Age-Adjusted Death Rate)	☁ 18.2	B 14.0	☁ 17.4	h 22.0	17.6	☁ 15.7	h 13.9	h 12.8
Mental Health Providers per 100,000	B 512.2	h 25.6	B 155.4	h 71.3	227.9	☁ 211.4	B 124.9	
% Taking Rx/Receiving Mental Health Trtmt	☁ 19.3	☁ 14.2	B 14.0	h 25.2	17.7		☁ 16.8	
% Unable to Get Mental Health Svcs in Past Yr	☁ 8.9	☁ 4.8	B 4.2	☁ 9.9	6.8		☁ 7.8	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

B better ☁ similar h worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
Population With Low Food Access (Percent)	B 18.1	h 55.5	25.8	B 13.6	26.1	23.1	22.2	
% "Very/Somewhat" Difficult to Buy Fresh Produce	16.8	B 7.0	16.5	19.5	15.7		B 21.1	
% 5+ Servings of Fruits/Vegetables per Day	B 36.7	34.1	25.3	h 18.7	29.2		32.7	
% No Leisure-Time Physical Activity	B 21.0	h 42.2	30.3	28.0	28.8	h 19.2	31.3	h 21.2
% Meeting Physical Activity Guidelines	B 30.8	h 14.2	23.3	22.9	24.2	25.9	21.4	h 28.4
% Child [Age 2-17] Physically Active 1+ Hours per Day					45.8		B 33.0	
Recreation/Fitness Facilities per 100,000	B 23.5	h 10.4	h 9.0	B 17.0	14.9	13.9	B 12.2	
% Overweight (BMI 25+)	70.8	B 63.2	h 76.0	73.0	71.8	h 64.0	h 61.0	
% Obese (BMI 30+)	38.0	B 27.9	40.1	34.1	36.5	h 28.3	h 31.3	36.0

% Children [Age 5-17] Overweight (85th Percentile)					48.0		h 32.3	
% Children [Age 5-17] Obese (95th Percentile)					35.7		h 16.0	h 15.5

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

B better ☁ similar h worse

ORAL HEALTH	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
% Have Dental Insurance	☁ 72.4	☁ 71.4	☁ 73.9	☁ 75.9	73.4		B 68.7	B 59.8
% [Age 18+] Dental Visit in Past Year	B 71.6	☁ 70.6	☁ 62.1	☁ 61.5	66.2	☁ 69.2	☁ 62.0	B 45.0
% Child [Age 2-17] Dental Visit in Past Year					93.3		B 72.1	B 45.0

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

B better ☁ similar h worse

POTENTIALLY DISABLING CONDITIONS	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
% 3+ Chronic Conditions	☁ 34.2	☁ 33.4	☁ 35.3	☁ 42.3	35.9		☁ 32.5	
% Activity Limitations	☁ 27.3	B 19.3	☁ 23.1	h 40.1	26.8		☁ 24.0	
% With High-Impact Chronic Pain	☁ 27.7	☁ 22.8	☁ 22.8	☁ 30.0	25.6		h 14.1	h 7.0

Alzheimer's Disease (Age-Adjusted Death Rate)	h 89.9	☁ 48.1	☁ 45.2	B 28.4	58.2	h 43.4	h 30.9	
% Caregiver to a Friend/Family Member	☁ 24.7	☁ 20.1	☁ 19.3	h 30.4	23.1		☁ 22.6	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

B better	☁ similar	h worse

	DISPARITY AMONG COUNTIES					TOTAL SERVICE AREA vs. BENCHMARKS		
RESPIRATORY DISEASE (INCLUDING COVID-19)	**Chelan County**	**Douglas County**	**Grant County**	**Okanogan County**	**Total Service Area**	**vs. WA**	**vs. US**	**vs. HP2030**
CLRD (Age-Adjusted Death Rate)	☁ 36.7	B 35.1	☁ 44.5	☁ 47.6	41.0	h 32.7	☁ 38.1	
Pneumonia/Influenza (Age-Adjusted Death Rate)	☁ 10.3		☁ 13.1		11.0	☁ 9.9	B 13.4	
% [Age 65+] Flu Vaccine in Past Year	☁ 74.5	B 85.9	h 64.9	☁ 73.9	73.3	B 67.8	☁ 71.0	
% [Adult] Asthma	☁ 10.0	☁ 9.3	☁ 11.4	☁ 12.6	10.8	☁ 9.9	☁ 12.9	
% [Child 0-17] Asthma					5.4		☁ 7.8	
% COPD (Lung Disease)	☁ 4.7	☁ 5.8	☁ 5.3	h 14.3	6.8	☁ 5.2	☁ 6.4	
% Avoided Medical Care Because of COVID-19	☁ 14.4	B 8.9	☁ 16.0	☁ 15.6	14.3			
% Fully/Partially Vaccinated for COVID-19	B 82.1	☁ 71.5	h 66.7	☁ 70.0	72.8			
% Using Alcohol More Often Since Pandemic Began	h	☁	☁	☁	6.7			

	9.5	4.3	4.9	7.5				
% Smoking/Vaping More Often Since Pandemic Began	☁ 5.4	B 0.0	☁ 4.9	☁ 1.7	3.7			
% Exercising Less Often Since Pandemic Began	☁ 23.2	☁ 24.3	☁ 21.3	B 13.2	21.0			
% Eating Unhealthy/Overeating More Often Since Pandemic Began	☁ 18.9	B 10.0	☁ 19.1	B 8.3	15.7			

RESPIRATORY DISEASE [INCLUDING COVID-19] (continued)	DISPARITY AMONG COUNTIES: Chelan County	Douglas County	Grant County	Okanogan County	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
% Arguing With HH Members More Often Since Pandemic Began	☁ 11.8	☁ 10.9	☁ 7.3	☁ 10.6	9.9			
% Getting Good Sleep Less Often Since Pandemic Began	☁ 22.3	☁ 18.1	☁ 18.9	B 12.1	18.7			
% Mental Health Worsened During the Pandemic	☁ 25.1	B 11.2	☁ 20.0	h 28.6	21.7			
% Financially Impacted by the Pandemic	☁ 24.9	☁ 18.9	☁ 21.7	B 14.3	21.0			
COVID-19 (Age-Adjusted Death Rate)	B 35.9		h 78.9	☁ 51.5	50.1	h 36.7	B 85.0	
						B better	☁ similar	h worse

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

SEXUAL HEALTH	DISPARITY AMONG COUNTIES: Chelan County	Douglas County	Grant County	Okanogan County	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS: vs. WA	vs. US	vs. HP2030
HIV Prevalence Rate	h 87.5	B 54.3	B 57.6	☁ 77.2	69.4	B 215.2	B 372.8	

Chlamydia Incidence Rate	373.7	431.5	399.3	B 297.1	380.2	B 465.2	B 539.9	
Gonorrhea Incidence Rate	B 58.8	81.1	h 116.6	B 31.1	79.5	B 151.3	B 179.1	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

B better	similar	h worse	

	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
SUBSTANCE ABUSE	**Chelan County**	**Douglas County**	**Grant County**	**Okanogan County**		**vs. WA**	**vs. US**	**vs. HP2030**
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	12.7		12.8	h 28.2	14.8	12.6	h 11.9	h 10.9
% Excessive Drinker	18.3	14.0	15.5	20.5	17.0	15.7	B 27.2	
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)	B 11.2		13.6	h 20.5	12.4	B 15.5	B 21.0	
% Illicit Drug Use in Past Month	2.6	B 0.0	1.7	1.2	1.6		2.0	B 12.0
% Used a Prescription Opioid in Past Year	B 13.0	15.5	18.5	h 27.4	17.9		h 12.9	
% Ever Sought Help for Alcohol or Drug Problem	7.6	6.4	h 3.4	B 11.2	6.6		5.4	
% Personally Impacted by Substance Abuse	43.5	39.7	B 35.4	h 49.3	41.1		h 35.8	

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

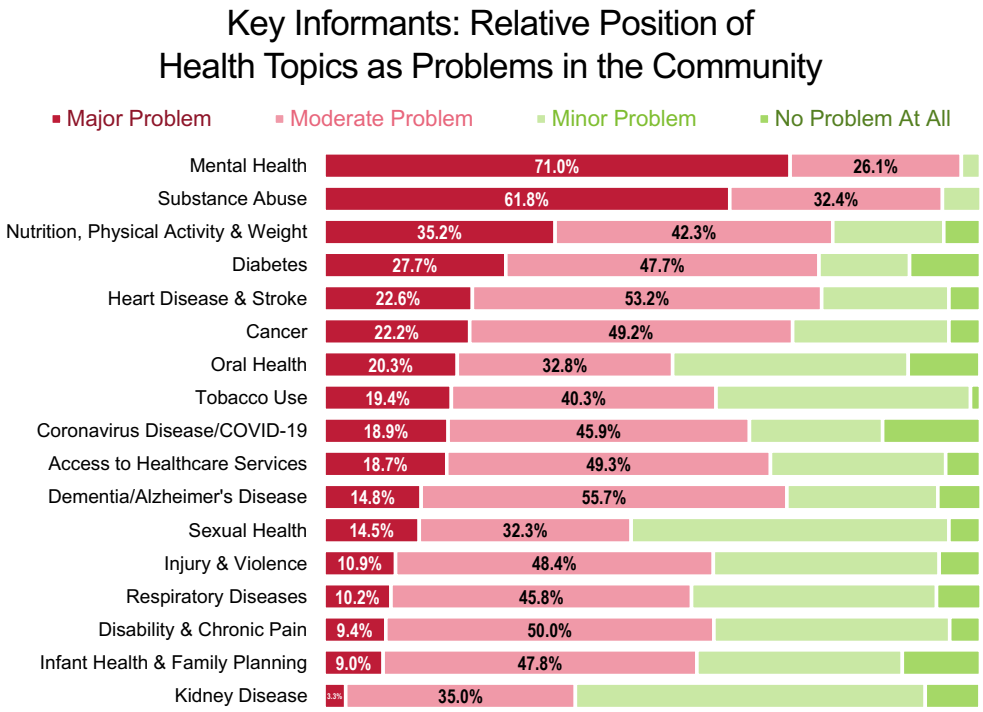
B better	similar	h worse

TOBACCO USE	DISPARITY AMONG COUNTIES				Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS		
	Chelan County	Douglas County	Grant County	Okanogan County		vs. WA	vs. US	vs. HP2030
% Current Smoker	13.7	B 8.1	15.2	h 21.8	14.7	12.7	17.4	h 5.0
% Someone Smokes at Home	9.8	9.4	9.5	15.5	10.6		B 14.6	
% [Household With Children] Someone Smokes in the Home					6.7		B 17.4	
% [Smokers] Have Quit Smoking 1+ Days in Past Year					44.3	56.0	42.8	h 65.7
% [Smokers] Received Advice to Quit Smoking					62.6		59.6	66.6
% Currently Use Vaping Products	1.7	2.8	4.5	2.1	2.9	B 4.3	B 8.9	
						B better	similar	h worse

Note: In the section above, each county is compared against all others combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues is a problem in their own community, using a scale of "major problem," "moderate problem," "minor problem," or "no problem at all." The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

The Total Service Area, the focus of this Community Health Needs Assessment, is comprised of Chelan, Douglas, Grant, and Okanogan counties; the combined area encompasses 12,686.11 square miles and houses a total population of 255,596 residents, according to latest census estimates.

Total Population
(Estimated Population, 2015-2019)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Chelan County	76,229	2,921.17	26
Douglas County	42,023	1,819.26	23
Grant County	95,502	2,679.49	36
Okanogan County	41,842	5,266.18	8
Total Service Area	255,596	12,686.11	20
WA	7,404,107	66,453.36	111
United States	324,697,795	3,532,068.58	92

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Population Change 2010-2020

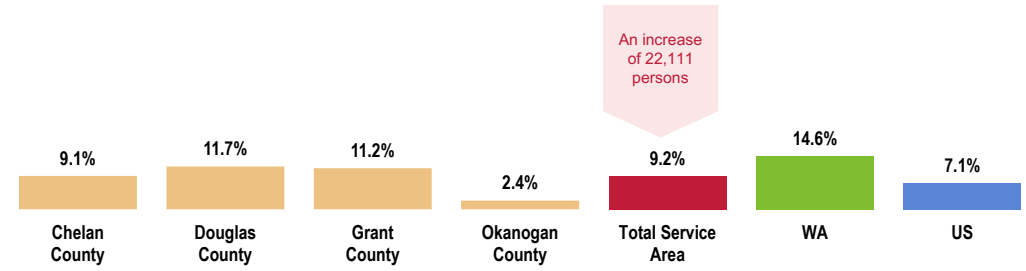
A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

Between the 2010 and 2020 US Censuses, the population of the Total Service Area increased by 22,111 persons, or 9.2%.

BENCHMARK ► Lower population increase than was found across the state of Washington.

DISPARITY ► Okanogan County recorded the lowest increase.

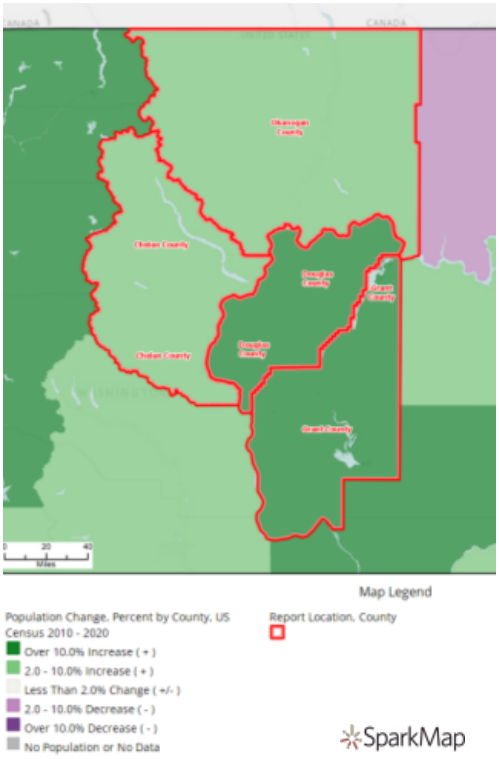
Change in Total Population
(Percentage Change Between 2010 and 2020)



Sources:
- US Census Bureau Decennial Census (2010-2020).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

This map shows the areas of greatest increase or decrease in population between 2010 and 2020.



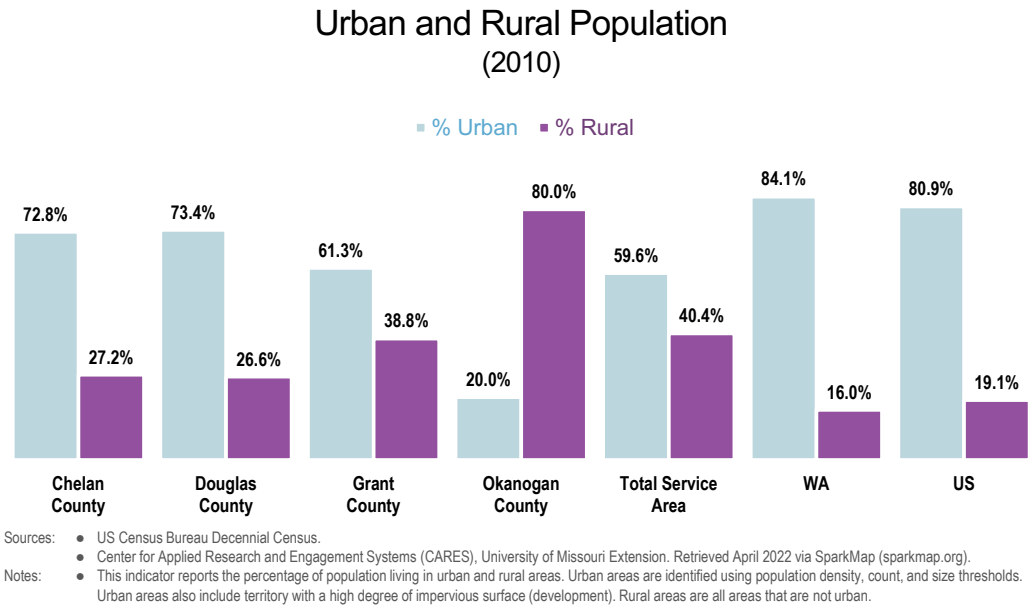
Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

The Total Service Area is predominantly urban, with 59.6% of the population living in areas designated as urban.

BENCHMARK ► More rural than the state and US overall.

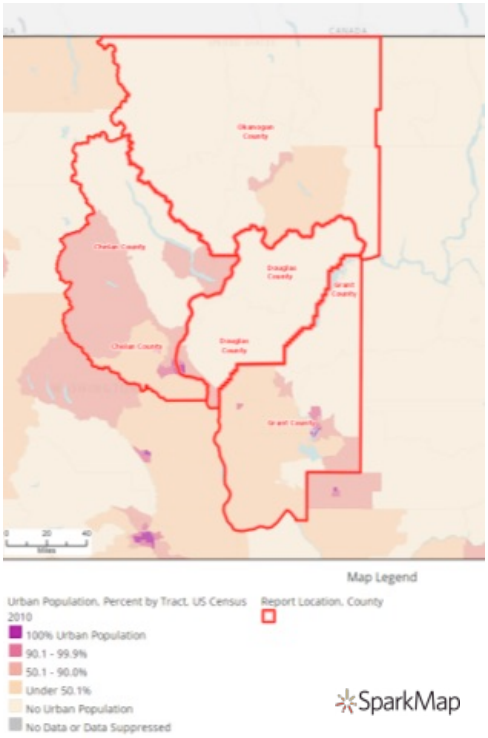
DISPARITY ► Okanogan County is the only predominantly rural county in the service area, while Chelan and Douglas counties are the most urban.



Sources:
- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

Note the following map, outlining the urban population in the Total Service Area.



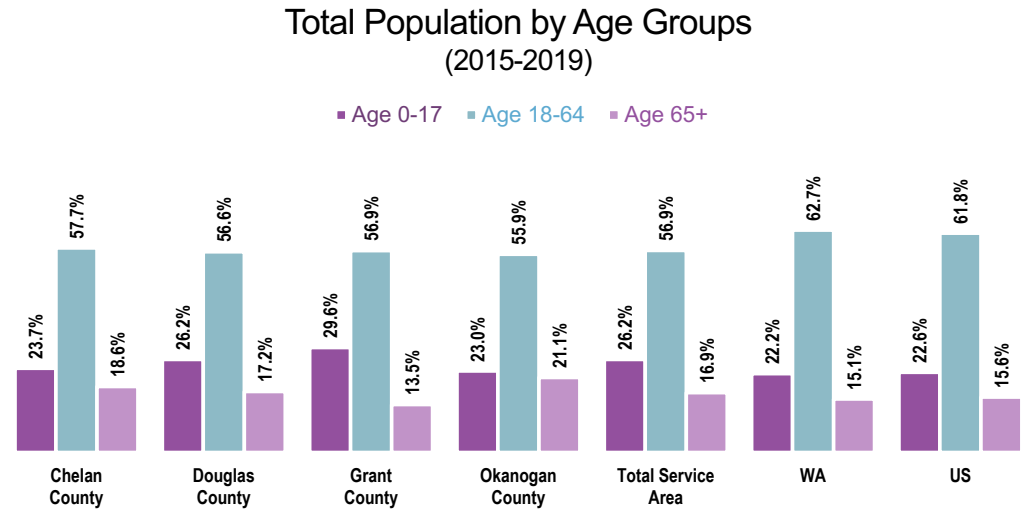
Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

In the Total Service Area, 26.2% of the population are children age 0-17; another 56.9% are age 18 to 64, while 16.9% are age 65 and older.

BENCHMARK ► Similar to state and national proportions.

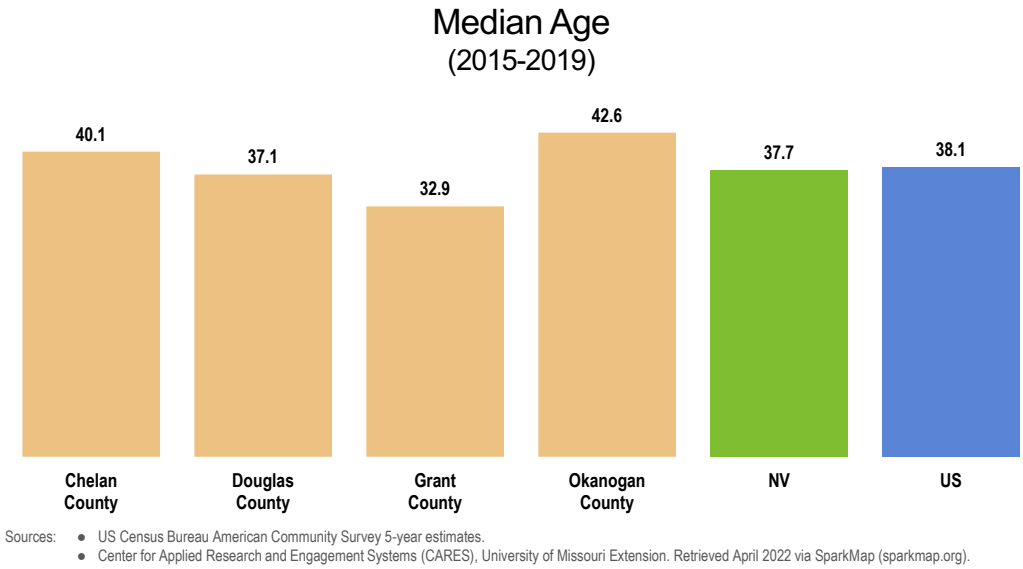
DISPARITY ► With regard to age distribution, Grant County skews the youngest and Okanogan County houses the largest proportion of seniors (age 65+).



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

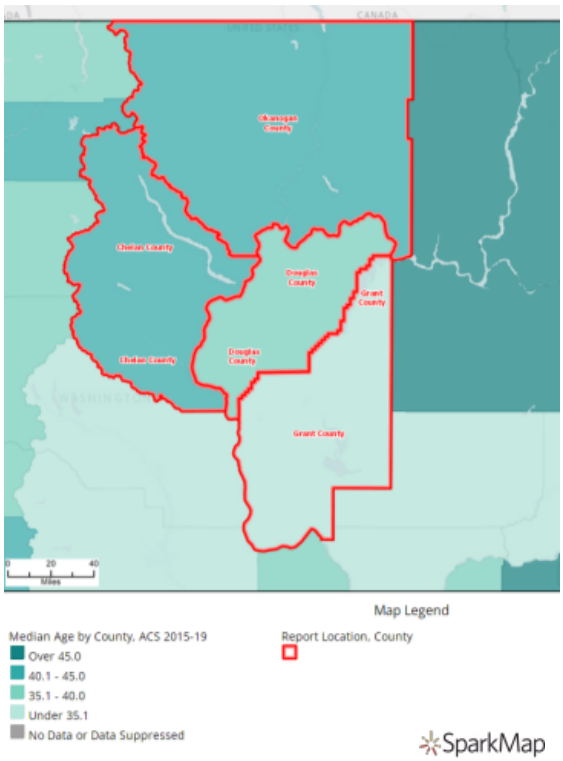
Median Age

Chelan and Okanogan counties are "older" than the state and US in that their median ages are higher.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

The following map provides an illustration of the median age in the Total Service Area.



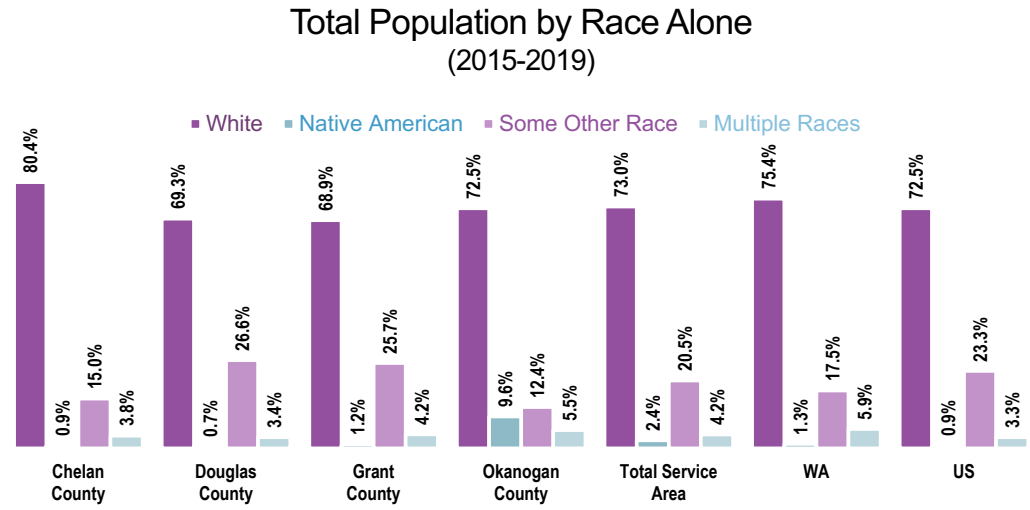
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 73.0% of residents of the Total Service Area are White and 2.4% are Native American.

BENCHMARK ► The percentage of residents who identify as Native American is higher in the Total Service Area than across the state or nation.

DISPARITY ► Okanogan County has the highest proportion of Native American residents.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

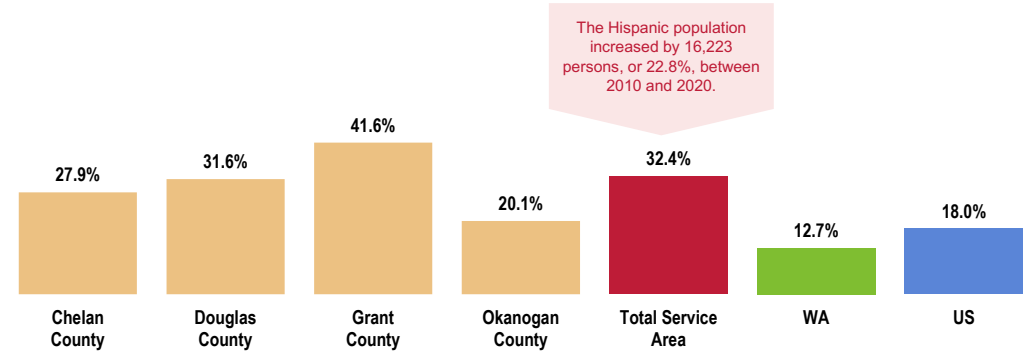
Ethnicity

A total of 32.4% of Total Service Area residents are Hispanic or Latino.

BENCHMARK ► Much higher than the state or national proportion.

DISPARITY ► Grant County is home to the highest proportion of Hispanic or Latino residents.

Hispanic Population
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

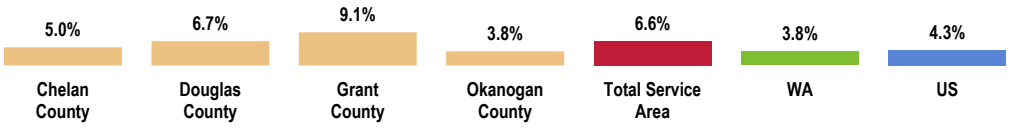
Linguistic Isolation

A total of 6.6% of the Total Service Area population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English "very well").

BENCHMARK ► Higher than the Washington and US findings.

DISPARITY ► Highest in Grant County.

Linguistically Isolated Population
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."

SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity – and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Income

Poverty

The latest census estimate shows 14.1% of the Total Service Area total population living below the federal poverty level.

BENCHMARK ► Higher than the Washington percentage. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Significantly higher in Okanogan County.

Among just children (ages 0 to 17), this percentage in the Total Service Area is 19.7% (representing an estimated 12,941 children).

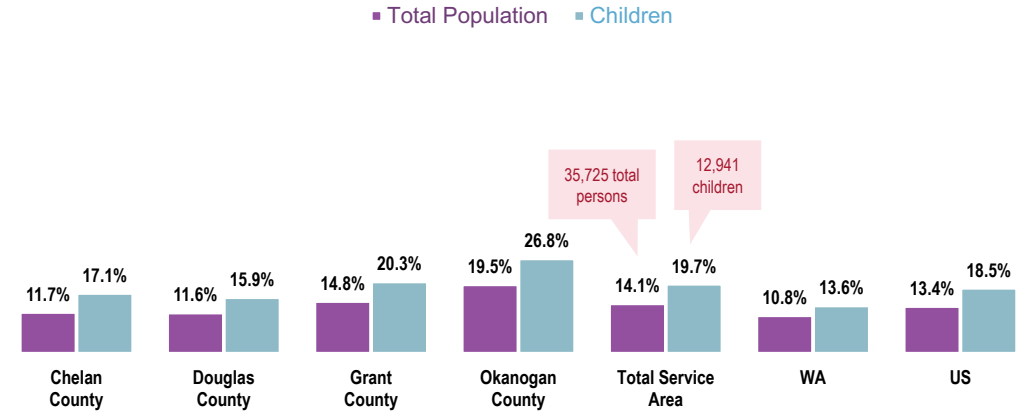
BENCHMARK ► Higher than the Washington percentage. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Significantly higher in Okanogan County.

Population in Poverty

(Populations Living Below the Poverty Level; 2015-2019)

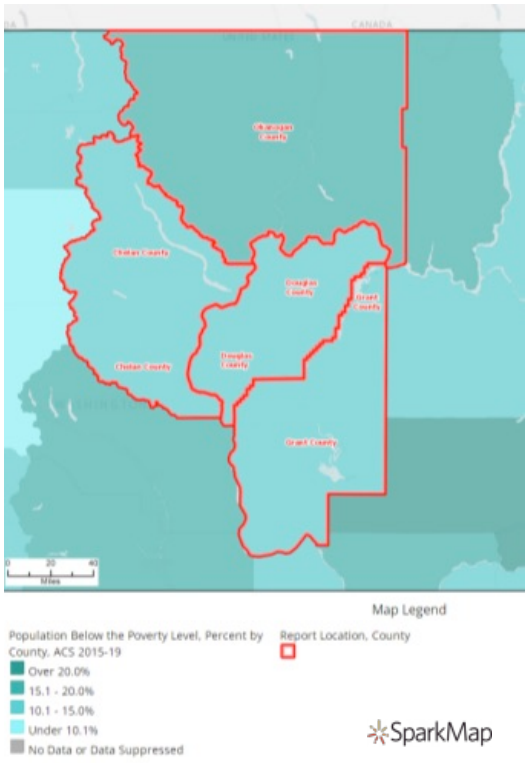
Healthy People 2030 = 8.0% or Lower

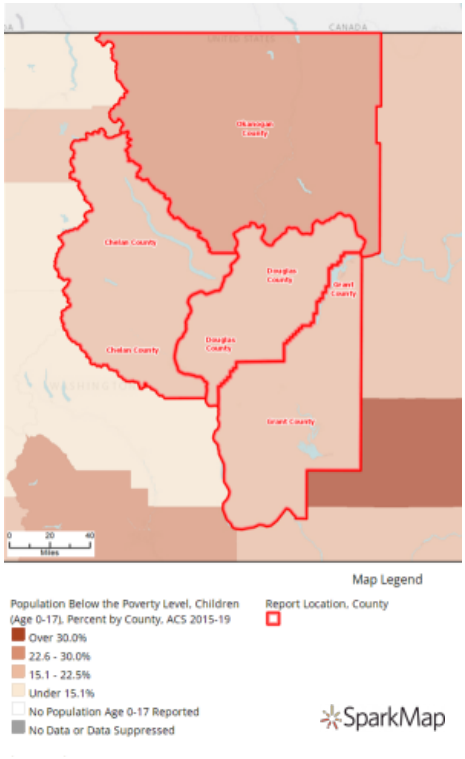


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

The following maps highlight concentrations of persons living below the federal poverty level.





Financial Resilience

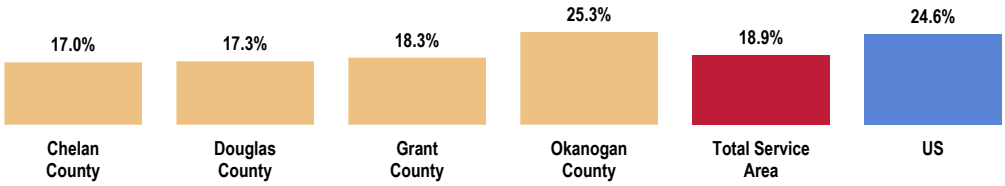
A total of 18.9% of Total Service Area residents would <u>not</u> be able to afford an unexpected $400 expense without going into debt.

BENCHMARK ► Favorably lower than the US percentage.

DISPARITY ► Significantly higher in Okanogan County. Significantly higher among residents aged 18 to 64 and especially low-income residents.

NOTE: For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically significant.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

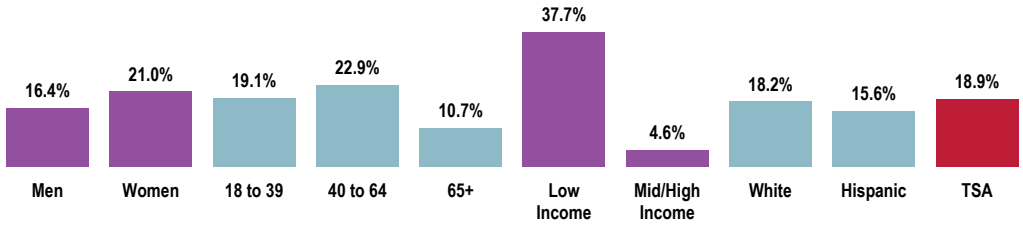
Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by sex, age groupings, income (based on poverty status), and race/ethnicity.

Here, "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

In addition, all Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).

Do Not Have Cash on
Hand to Cover a $400 Emergency Expense
(Total Service Area, 2022)



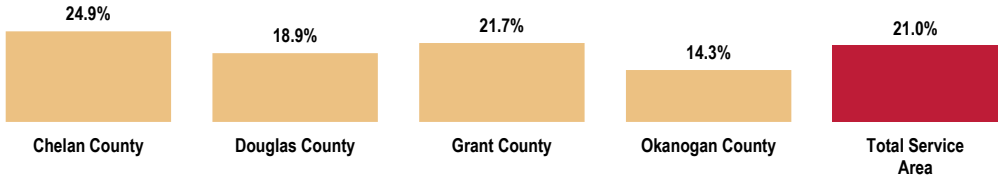
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 63]
Notes: ● Asked of all respondents.
● Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Financial Impact of the Pandemic

A total of 21.0% of Total Service Area residents reported that, since March 2020, they or another household member lost a job, worked fewer hours, or lost health insurance coverage.

DISPARITY ► Lowest in Okanogan County. Residents under 65 years old were more likely to be financially impacted by the pandemic.

Financially Impacted by the Pandemic



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: • Asked of all respondents.
• Includes respondents reporting that they or another household member lost a job, worked fewer hours, or lost health insurance coverage since March 2020.

Financially Impacted by the Pandemic
(Total Service Area, 2022)

Sources: • PRC Community Health Survey, Professional Research Consultants, Inc. [Item 303]
Notes: • Asked of all respondents.
• Includes respondents reporting that they or another household member lost a job, worked fewer hours, or lost health insurance coverage since March 2020.

Education

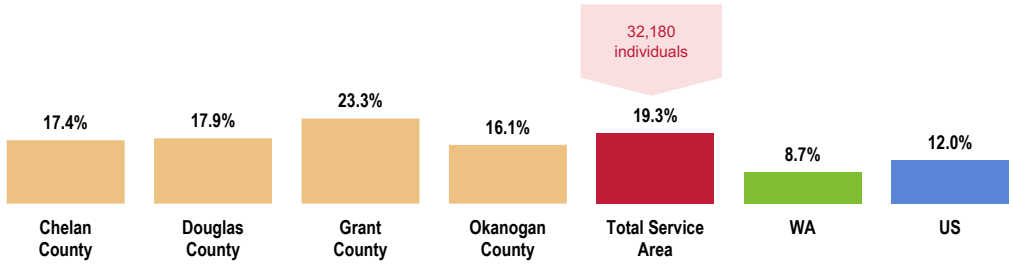
Among the Total Service Area population age 25 and older, an estimated 19.3% (over 32,180 people) do not have a high school education.

BENCHMARK ► Higher than both the Washington and US percentages.

DISPARITY ► Significantly higher in Grant County.

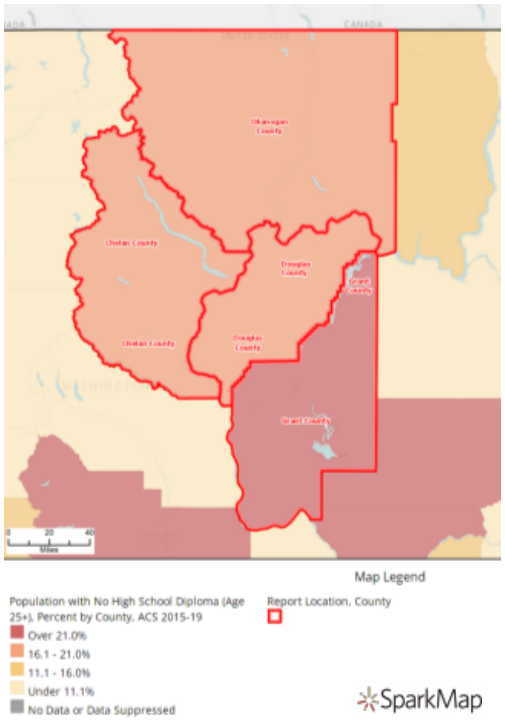
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.



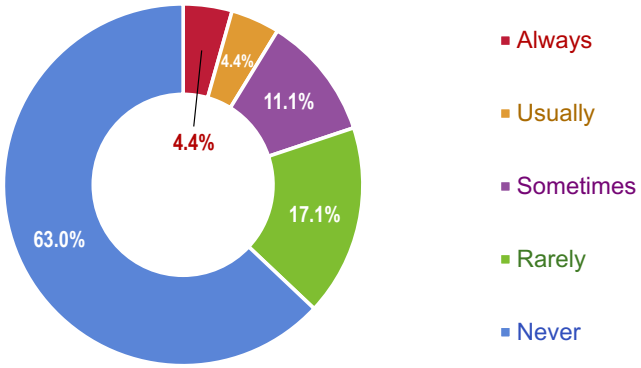
Respondents were asked: "Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

Housing

Housing Insecurity

Most surveyed adults rarely, if ever, worry about the cost of housing.

Frequency of Worry or Stress
Over Paying Rent or Mortgage in the Past Year
(Total Service Area, 2022)



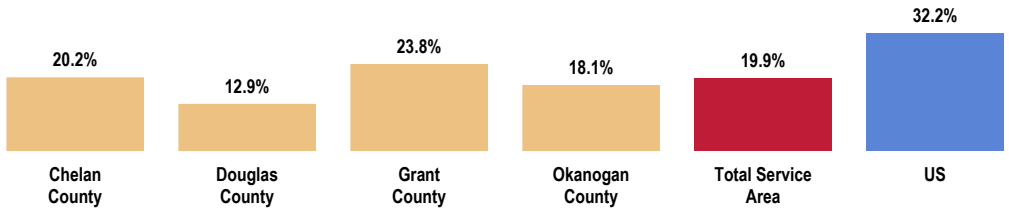
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: • Asked of all respondents.

However, a considerable share (19.9%) report that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

BENCHMARK ► Lower than the US finding.

DISPARITY ► Significantly higher in Grant County. Reported more often among women, those under 65, and especially low-income residents.

"Always/Usually/Sometimes" Worried
About Paying Rent/Mortgage in the Past Year



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

"Always/Usually/Sometimes" Worried
About Paying Rent/Mortgage in the Past Year
(Total Service Area, 2022)

Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

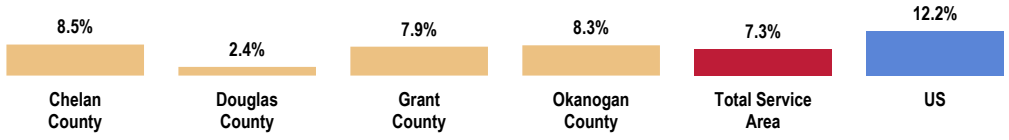
Respondents were asked: "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

A total of 7.3% of Total Service Area residents report living in unhealthy or unsafe housing conditions during the past year.

BENCHMARK ▶ Favorably lower than the US percentage.

DISPARITY ▶ Favorably low in Douglas County. Reported more often among adults aged 40 to 64 and low-income residents.

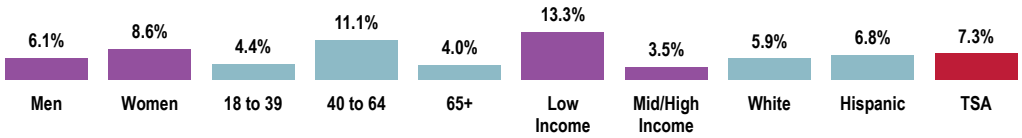
Unhealthy or Unsafe Housing Conditions in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 65]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(Total Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 65]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Food Access

Low Food Access

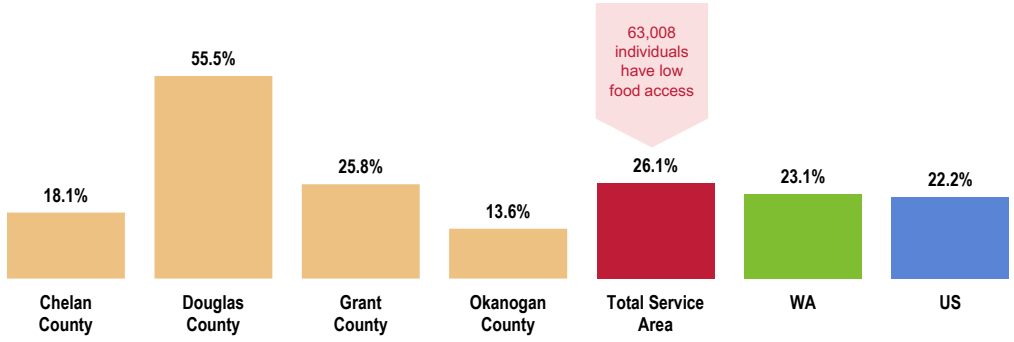
Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* in the **Modifiable Health Risks** section of this report.

US Department of Agriculture data show that 26.1% of the Total Service Area population (representing over 63,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

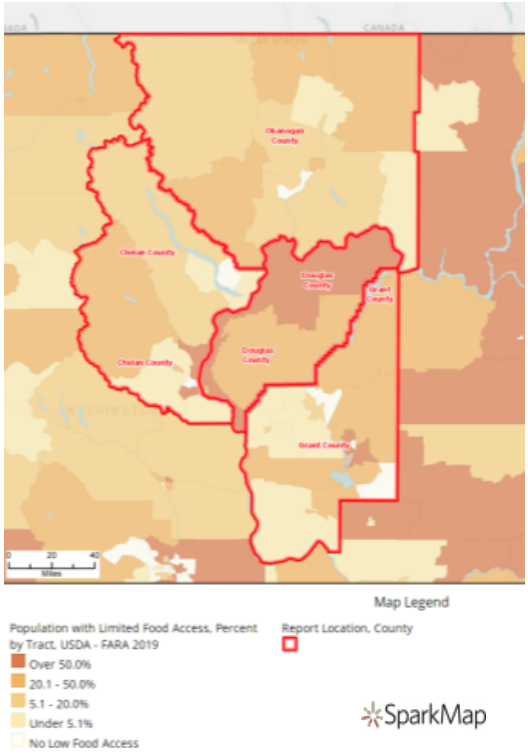
DISPARITY ▶ Much higher in Douglas County.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.



Food Insecurity

Overall, 18.7% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

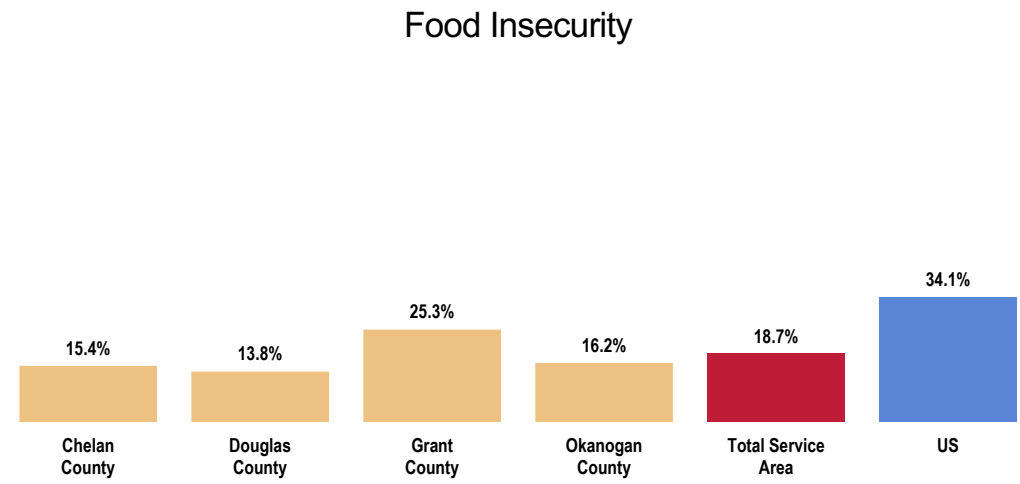
BENCHMARK ► Much lower than the US percentage.

DISPARITY ► Unfavorably high in Grant County. Those under the age of 65 and lower-income residents (especially) are more likely to be food insecure.

Surveyed adults were asked: "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was "Often True," "Sometimes True," or "Never True" for you in the past 12 months:

- I worried about whether our food would run out before we got money to buy more.
- The food that we bought just did not last, and we did not have money to get more."

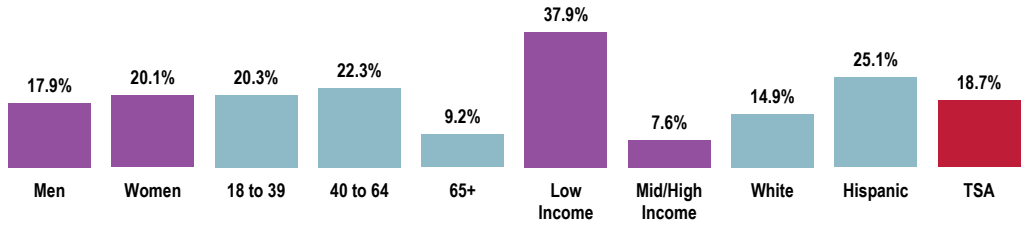
Those answering "Often" or "Sometimes True" for either statement are considered to be food insecure.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 112]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecurity
(Total Service Area, 2022)



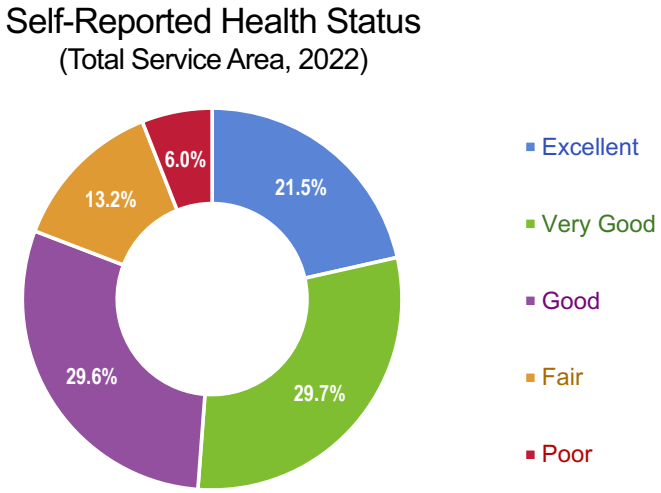
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 112]
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

HEALTH STATUS

OVERALL HEALTH STATUS

The initial inquiry of the PRC Community Health Survey asked: "Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?"

Most Total Service Area residents rate their overall health favorably (responding "excellent," "very good," or "good").

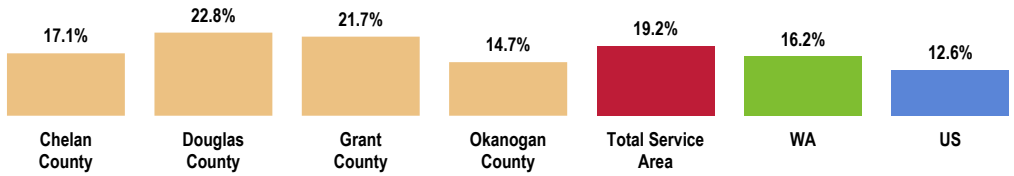


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

However, 19.2% of Total Service Area adults believe that their overall health is "fair" or "poor."

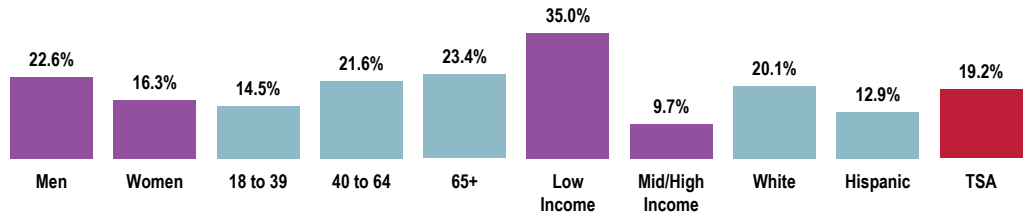
BENCHMARK ► Worse (higher) than the Washington and US findings.

DISPARITY ► The prevalence increases with age and is reported more often among men and lower-income adults.



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

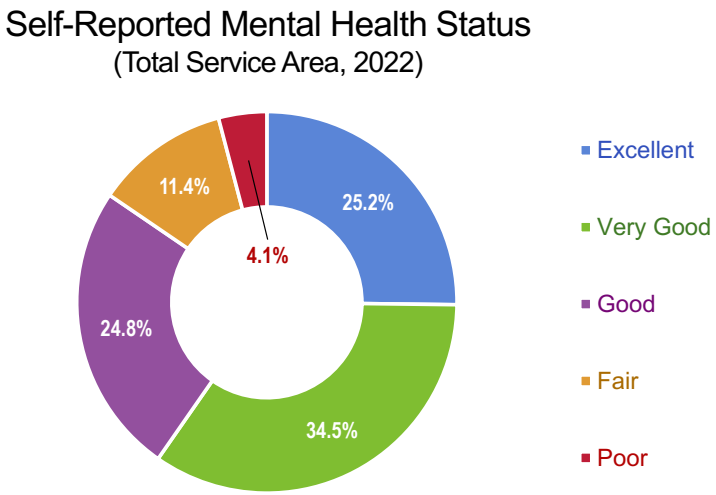
– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

Self-Reported Mental Health

"Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: Excellent, Very Good, Good, Fair, or Poor?"

Most Total Service Area adults rate their overall mental health favorably ("excellent," "very good," or "good").

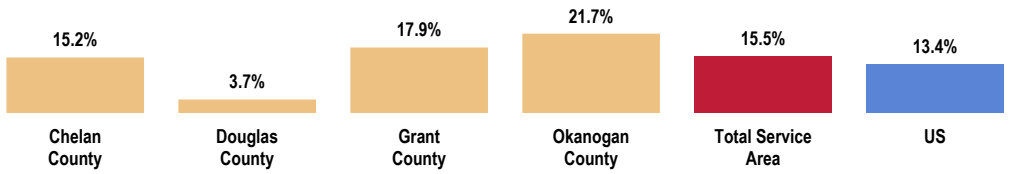


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: • Asked of all respondents.

However, 15.5% believe that their overall mental health is "fair" or "poor."

DISPARITY ► Highest in Okanogan County.

Experience "Fair" or "Poor" Mental Health



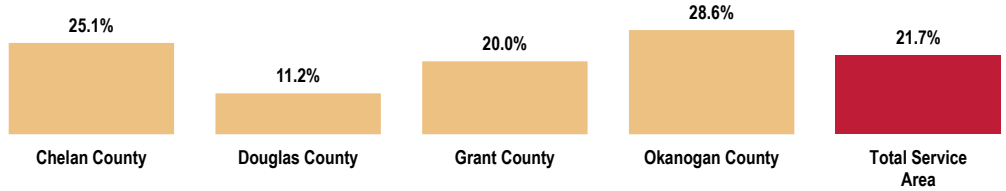
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Effects of the Pandemic on Mental Health

A total of 21.7% of Total Service Area adults report that their mental health has gotten worse since the beginning of the pandemic.

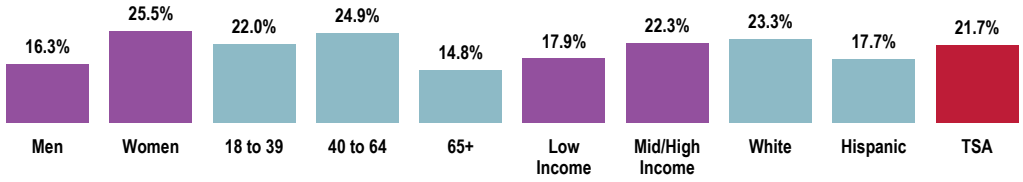
DISPARITY ► Highest in Okanogan County. More often reported among women and adults aged 18 to 64.

Mental Health Has Gotten Worse
Since the Beginning of the Pandemic



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: ● Asked of all respondents.
● Beginning of pandemic specified as March 2020.

Mental Health Has Gotten Worse Since the Beginning of the Pandemic
(Total Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 302]

Notes:
- Asked of all respondents.
- Beginning of pandemic specified as March 2020.

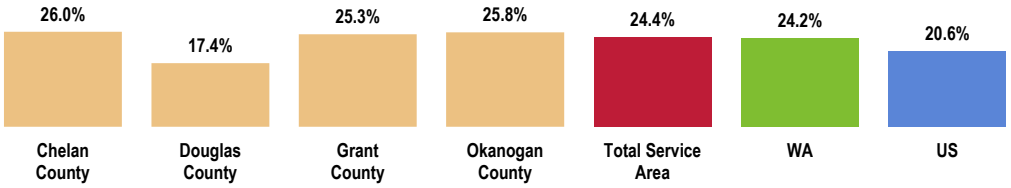
Depression

Diagnosed Depression

A total of 24.4% of Total Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

DISPARITY ► Significantly better (lower) in Douglas County.

Have Been Diagnosed With a Depressive Disorder



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

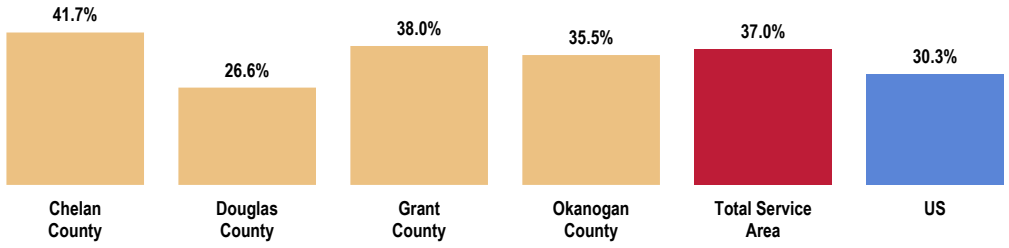
Symptoms of Chronic Depression

A total of 37.0% of Total Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

BENCHMARK ► Higher than the US percentage.

DISPARITY ► Lowest in Douglas County. More often reported among women, those under the age of 65, and lower-income residents.

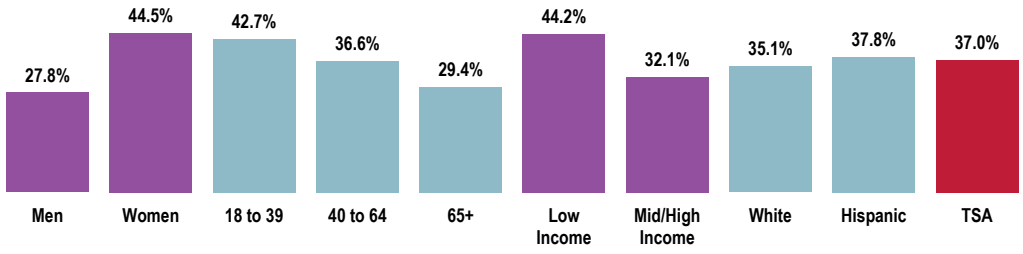
Have Experienced Symptoms of Chronic Depression



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression
(Total Service Area, 2022)

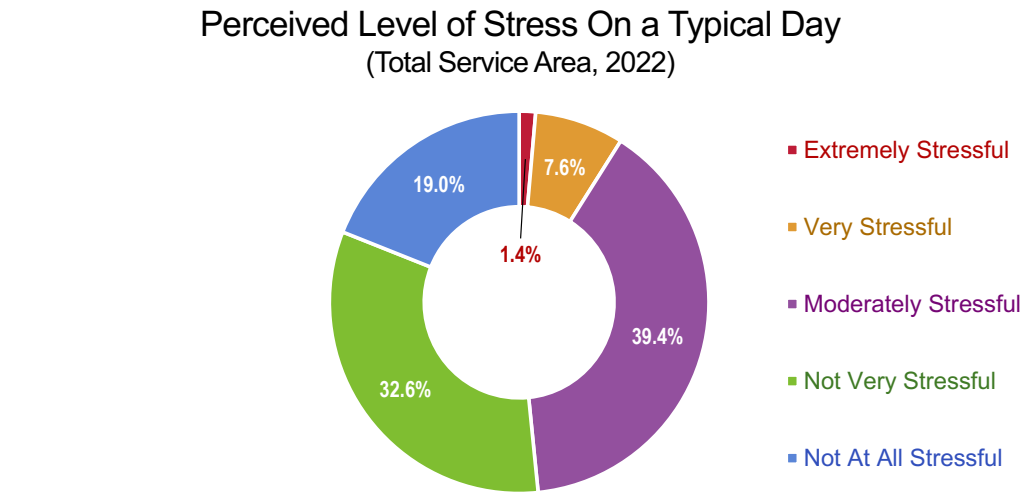


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 91]

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Stress

A majority of surveyed adults characterize most days as no more than "moderately" stressful.

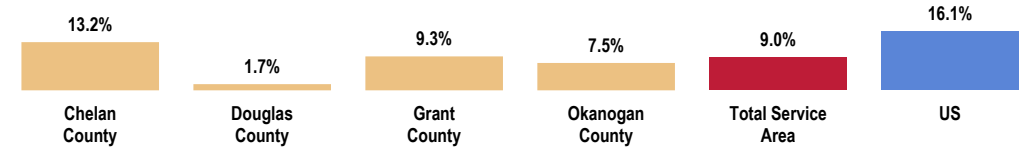


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: • Asked of all respondents.

In contrast, 9.0% of Total Service Area adults feel that most days for them are "very" or "extremely" stressful.

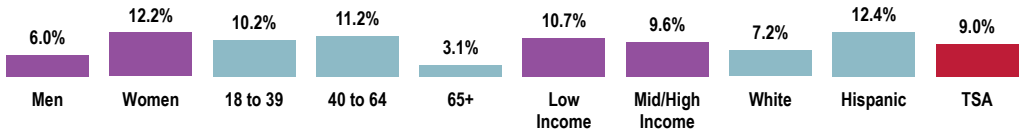
BENCHMARK ► Lower than the US finding.

DISPARITY ► Significantly higher in Chelan County. More often reported by women and adults under 65.



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 92]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Perceive Most Days as “Extremely” or “Very” Stressful
(Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: • Asked of all respondents.

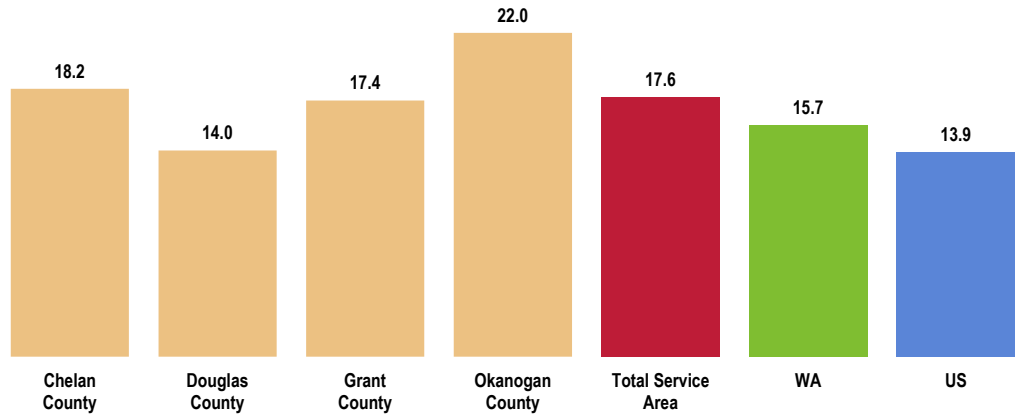
Suicide

In the Total Service Area, there were 17.6 suicides per 100,000 population (2018-2020 annual average age-adjusted rate).

BENCHMARK ► Worse than the US rate and fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Unfavorably high in Okanogan County.

Suicide: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
• US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Mental Health Treatment

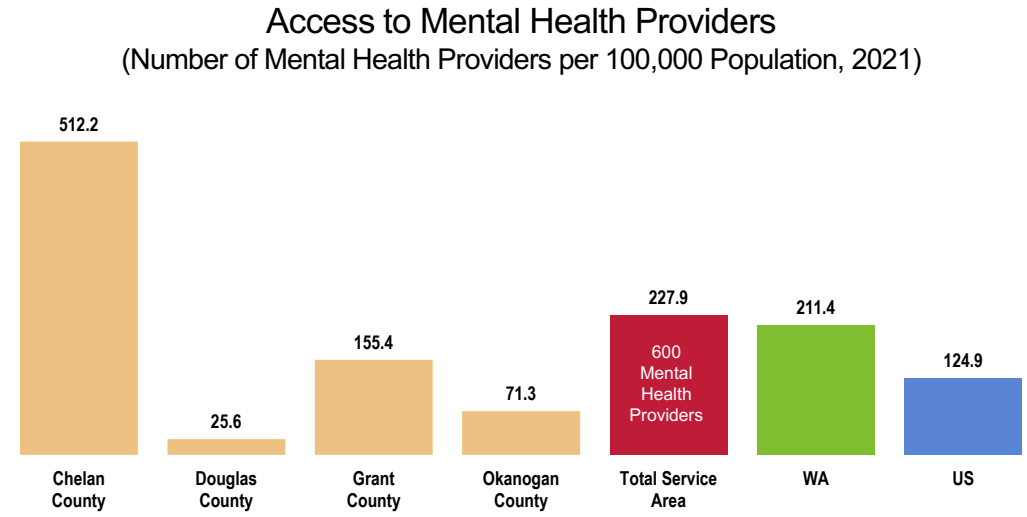
Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the Total Service Area and residents in the Total Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

In 2021, the service area reported 227.9 mental health providers for every 100,000 population.

BENCHMARK ▶ Much higher than the US rate.

DISPARITY ▶ Significantly fewer mental health providers in Douglas and Okanogan Counties.



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

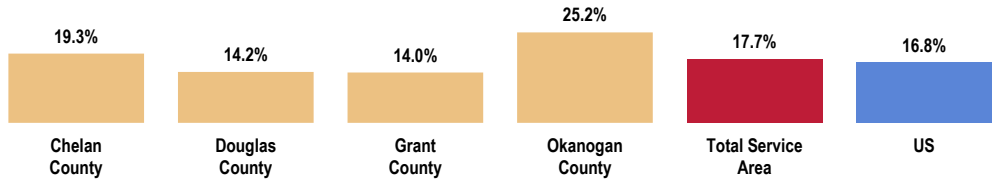
Currently Receiving Treatment

A total of 17.7% of respondents are currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

DISPARITY ▶ Highest in Okanogan County.

Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 53.8% are currently receiving treatment.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2020 PRC National Health Survey, PRC, Inc.

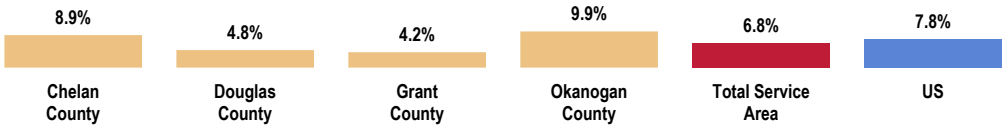
Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

Difficulty Accessing Mental Health Services

A total of 6.8% of Total Service Area adults report a time in the past year when they needed mental health services but were not able to get them.

DISPARITY ► Favorably low in Grant County. Reported more often among women, respondents under 65, and low-income residents.

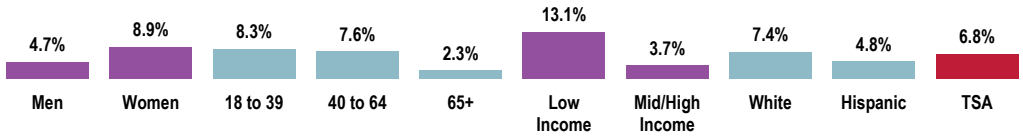
Unable to Get Mental Health Services When Needed in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 95]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

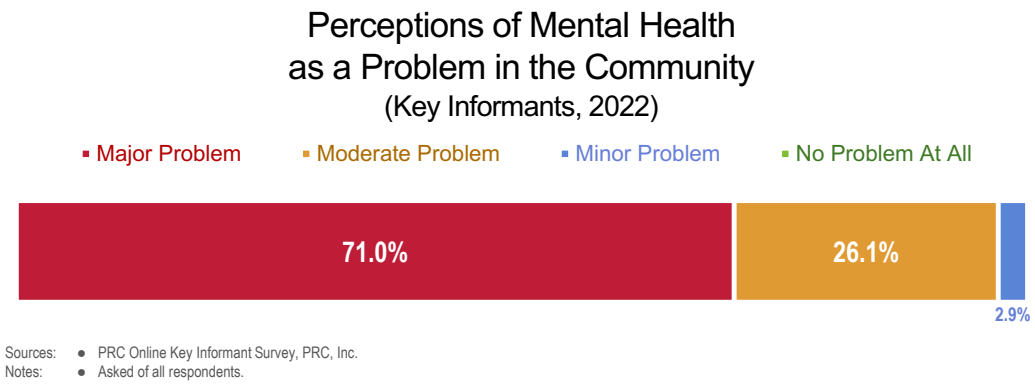
Unable to Get Mental Health Services When Needed in the Past Year
(Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 95]
Notes: • Asked of all respondents.

Key Informant Input: Mental Health

The greatest share of key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Lack of resources for behavioral and mental health assistance, especially in the justice system. A behavioral health/diversion center at the county/regional level would help alleviate this issue in our community. – Community Leader

There are not enough mental health services available. Specifically, counselors who treat kids. Also, many have a religious affiliation which is a barrier to many. – Community Leader

Access to care, especially crisis care. – Community Leader

Access to qualified mental health professionals and facilities to house those who need a higher level of mental health care. – Community Leader

Access to behavioral health and supportive services is very limited right now, especially with Covid. – Social Services Provider

Mental health is and going to continue being a major problem. In our area access to mental health is very much lacking. Access to help is over one hour away and often lacking in urgency by the facilitating agency. – Community Leader

Timely access to mental health or behavioral health services. – Public Health Representative

Access for second language and students from poverty. Lack of availability in appointments for services. – Community Leader

Not enough services available. – Community Leader

Access to mental health professionals. – Social Services Provider

There are too few therapists for those who have Medicaid or have few economic resources to afford therapy. There aren't enough programs for people who need substance abuse treatment and behavioral health services. There aren't enough low-or-no-barrier programs or facilities for people with co-occurring issues. – Public Health Representative

Access to affordable care. – Community Leader

Availability of services. These services are not funded adequately. If I'm correct, the state cut funding several years ago. Law enforcement and the jail are not set up to handle these patients. – Community Leader

Long waiting list to receive mental health care or no health coverage. – Social Services Provider

We have no inpatient services. With the increasing community mental health problems, we need better access to overall mental health care. – Community Leader

Accessing care and overcoming their underlying conditions, such as addiction. OBHC does not provide the services necessary to address the real issues. The board there is more interested in personal gain than doing anything to better the community. – Community Leader

Contributing Factors

There does not seem to be good coordination between MH service providers. A holistic view approach is needed to ensure that prevention, crisis care, and post recovery navigation is in place. This includes street level diversion, pro-active response to individuals that miss appointments or are in need of welfare checks which requires open communication between physicians, care teams and pro-active response teams. Additionally, a centralized location for those that wish to voluntarily commit, are involuntarily committed, and are court ordered for treatment needs to be stood up. The post treatment should include navigators who provide assistance and preventative measures to aid the individual in re-introduction to active community participation. There is a need for crisis stabilization chairs in remote communities to ensure individuals in crisis have the necessary assistance when it is needed, Job training, housing and food security are essential to reintegration after treatment. – Community Leader

Lack of ability to access care or the ability to pay for that care. – Social Services Provider

Lack of sufficient personnel (due to budget constraints) at Okanogan Behavioral Health Center to deal with problems when they arise – on time delivery of services during a crisis. Additionally, many MDs are not in touch with how to refer clients to services within clinics that might help reduce stressors, or to other agencies that could also provide assistance such as a provider who does not refer a domestic partner exhibiting signs of domestic violence to the Support Center and does not have the knowledge of services to make a meaningful referral and do a follow-up with the patient. – Social Services Provider

So many levels of this right now. From the extreme of homelessness and screamers on the street to our teens struggling with all the changes and ever moving target of navigation for them. Where can people go for help? Who are at risk and how can that be addressed? The community as a whole struggling with 2 years of restrictions and no end in sight. Someone told me the other day that they are "so tired of the moving target". They are "so done". – Community Leader

Patients that do not have the resources financially or capacity to get help. – Community Leader

Mental Health is becoming more prevalent in the community. This in conjunction with homelessness and substance abuse leads to more crime. Being a rural community, it is difficult to find the personnel that are trained and specialized to handle to issues. – Community Leader

We need support for those with mental health issues. – Community Leader

Not getting accessible help that best meets their needs. Lack of confidentiality from providers in our small town (many HIPPA violations) has created a severe lack of trust from clients. Stigmatization and other narratives around mental health being a liberal issue. – Social Services Provider

Few practitioners, cost, stigma associated with mental health issues. – Community Leader

Lack of community conversation over mental health during COVID pandemic. Lack of understanding who to call when there is an issue (I've seen firefighters intervene with interactions between people with mental health and businesses downtown Moses Lake.) Lack of places for people with mental illness to go for resources, recreation/daytime activities. – Community Leader

Our State has, for all intents and purposes, made hard drug possession and use legal. This has added to the years of under investing in mental health services. When the legislature changed the mission of Eastern and Western State Hospitals, making them more of diagnostic facilities, they did not invest in local facilities that could treat those in mental health crisis or those with chronic mental health disease. Most of these individuals are incapable of making health decisions for themselves, which makes voluntary treatment institutions useless. Family support networks have failed, mostly out of frustration with our current systems. Our same legislators have made very narrow parameters for which to involuntarily mandate treatment. These same conditions have added to our State's homeless populations. – Community Leader

Lack of Providers

Not enough behavioral health providers of all types. Takes too long to get in to see a behavioral health provider. Very limited inpatient services across the state, particularly limited for youth and people with comorbidities. Also, our ED staff feel the DMHP (I know there's a new title for this, which is escaping me at the moment) is reluctant to ever refer patients on for additional care, exacerbating potential access issues for patients and families. – Other Health Provider

Lack of mental health professionals, lack of crisis counselors. – Public Health Representative

Lack of access to behavioral health care providers and inadequate telehealth to meet behavioral health demand. – Other Health Provider

Lack of therapists and trauma informed services, need more behavioral health therapists, anger management, domestic violence, family therapists, youth/young adult and LGBTQ+ specialists. – Social Services Provider

> Not enough mental health providers, distrust of mental health/counseling, cost of services, hours of operation don't work for working poor, lack of Spanish speaking mental health providers and services, need for dual diagnosis services (substance use disorder treatment and mental health care). – Social Services Provider
>
> There are not enough providers, full stop. – Community Leader
>
> Lack of available health care providers and crisis response. – Other Health Provider

Denial/Stigma

> There is still a stigma associated with seeking help and being open about mental health issues. – Social Services Provider
>
> Self-recognition of the problem. Homeless individuals. Stigma that keeps people away from getting help. – Community Leader
>
> Getting the help needed. A mental health label is undesirable. – Community Leader

Incidence/Prevalence

> Affects so many people, mainly young adults. – Community Leader
>
> Resilience and coping skills of so many adults and now children is staggering. I am concerned for this generation of children and their parents not being able to cope with changes and challenges. This has impacted the workforce, benefits, and productivity and services. – Community Leader
>
> Mental health and prevalence of suicide. – Public Health Representative
>
> Behavioral Health. There is not enough crossover into the other avenues of health with behavioral health AND there are not enough providers for dual diagnosis folks (ex. behavioral health/substance abuse). Each sector is completely siloed, which leaves a lot of giant gaps that folks fall through. – Community Leader
>
> They are wandering the streets, filling the jails, abusing drugs, and suicidal. – Community Leader

Due to COVID-19

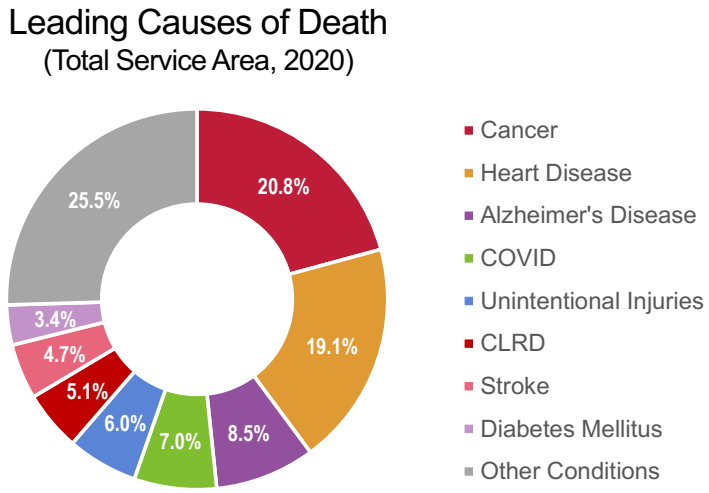
> I feel like the pandemic has exasperated people's sense of isolation from others and has brought to light a lot of mental health challenges that were otherwise unknown. It has also added a lot of stress on people and may have created new mental health challenges. – Community Leader
>
> So don't really know what to do about it, but a huge issue is a lack of kindness and humanity I am seeing in my community. We are known here for how unique sense of place, and that, due to COVID has seemed to have changed. Angry people on social media, angry drivers, angry customers in stores, angry passengers on planes. Also our exhausted health care professionals that have not had a break from this. They have to get up, go to work and do their job. We all need a mental wellness day. Thank you so much for allowing me to answer these questions. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, cancers and heart disease accounted for 40% of all deaths in the Total Service Area in 2020.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Washington and the United States), it is necessary to look at rates of death – these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Death Rates for Selected Causes

The following chart outlines 2018-2020 annual average age-adjusted death rates per 100,000 population for selected causes of death in the Total Service Area.
Each of these is discussed in greater detail in subsequent sections of this report.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	Total Service Area	WA	US	HP2030
Malignant Neoplasms (Cancers)	148.0	142.5	146.5	122.7
Diseases of the Heart	139.8	134.9	164.4	127.4*
Falls [Age 65+]	63.9	91.7	67.0	63.4
Alzheimer's Disease	58.2	43.4	30.9	—
COVID-19 [2020]	50.1	36.7	85.0	—
Unintentional Injuries	47.8	45.6	51.6	43.2
Chronic Lower Respiratory Disease (CLRD)	41.0	32.7	38.1	—
Cerebrovascular Disease (Stroke)	35.0	34.6	37.6	33.4
Diabetes	23.5	21.2	22.6	—
Intentional Self-Harm (Suicide)	17.6	15.7	13.9	12.8
Cirrhosis/Liver Disease	14.8	12.6	11.9	10.9
Firearm-Related	13.0	10.7	12.5	10.7
Unintentional Drug-Related Deaths	12.4	15.5	21.0	—
Motor Vehicle Deaths	11.8	8.0	11.4	10.1
Pneumonia/Influenza	11.0	9.9	13.4	—
Homicide/Legal Intervention	3.9	3.3	5.9	5.5
Kidney Disease	3.0	4.6	12.8	—

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency – like stroke, heart attack, or cardiac arrest – get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

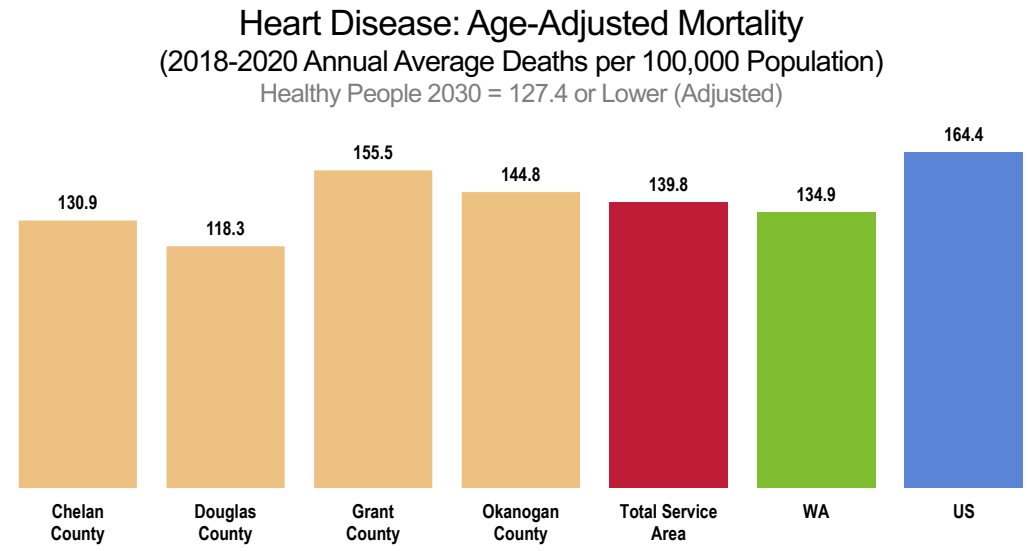
Heart Disease Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

Between 2018 and 2020, there was an annual average age-adjusted heart disease mortality rate of 139.8 deaths per 100,000 population in the Total Service Area.

BENCHMARK ► Lower than the national mortality rate.

DISPARITY ► Lowest in Douglas County.



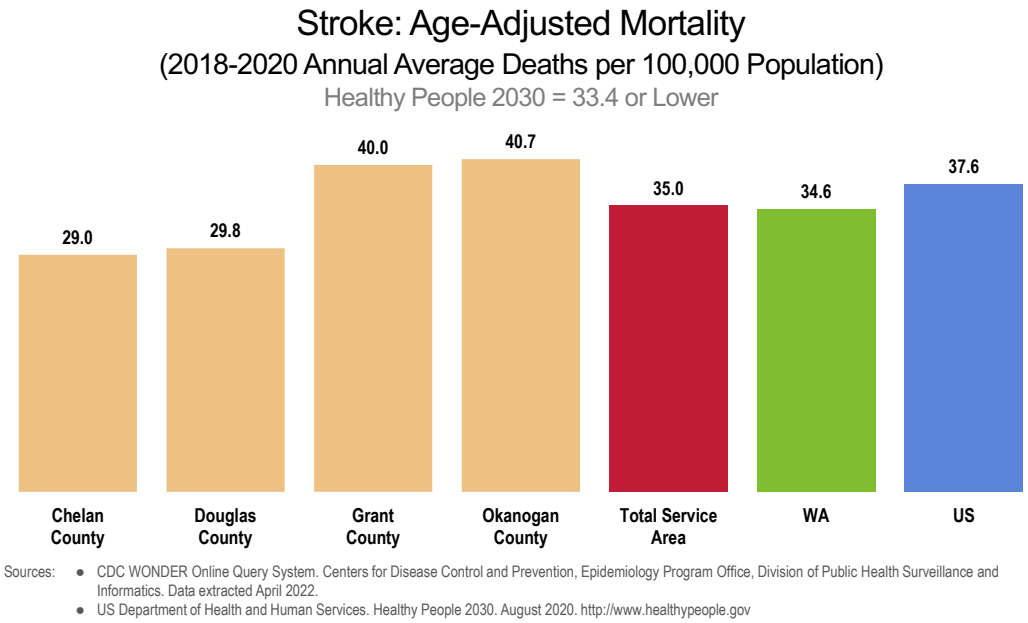
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke Deaths

Between 2018 and 2020, there was an annual average age-adjusted stroke mortality rate of 35.0 deaths per 100,000 population in the Total Service Area.

DISPARITY ► Higher in Grant and Okanogan counties.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

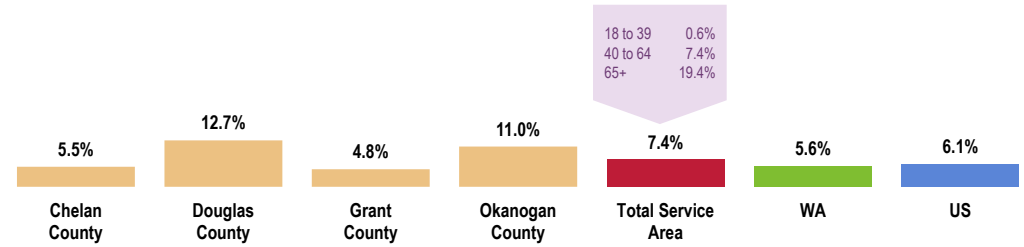
Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

A total of 7.4% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

DISPARITY ► Favorably low in Grant County. Strong correlation with age in the service area.

Prevalence of Heart Disease



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

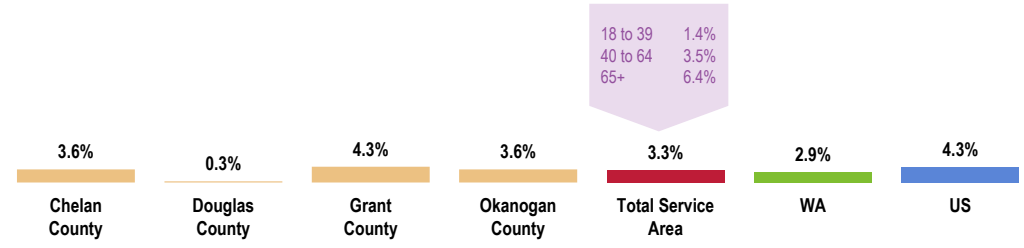
Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

Prevalence of Stroke

A total of 3.3% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).

DISPARITY ► Lowest in Douglas County. Stroke prevalence correlates with age in the Total Service Area.

Prevalence of Stroke



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

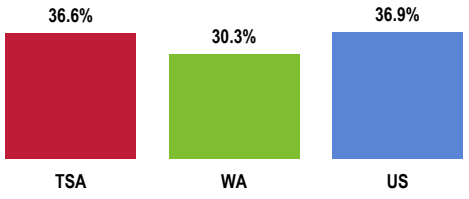
A total of 36.6% of Total Service Area adults have been told by a health professional at some point that their blood pressure was high.

BENCHMARK ► Higher than the Washington finding. Fails to satisfy the Healthy People 2030 objective.

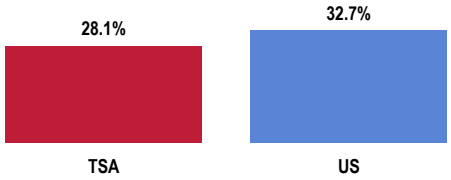
A total of 28.1% of adults have been told by a health professional that their cholesterol level was high.

BENCHMARK ► Better (lower) than the national percentage.

Prevalence of
High Blood Pressure
Healthy People 2030 = 27.7% or Lower



Prevalence of
High Blood Cholesterol



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

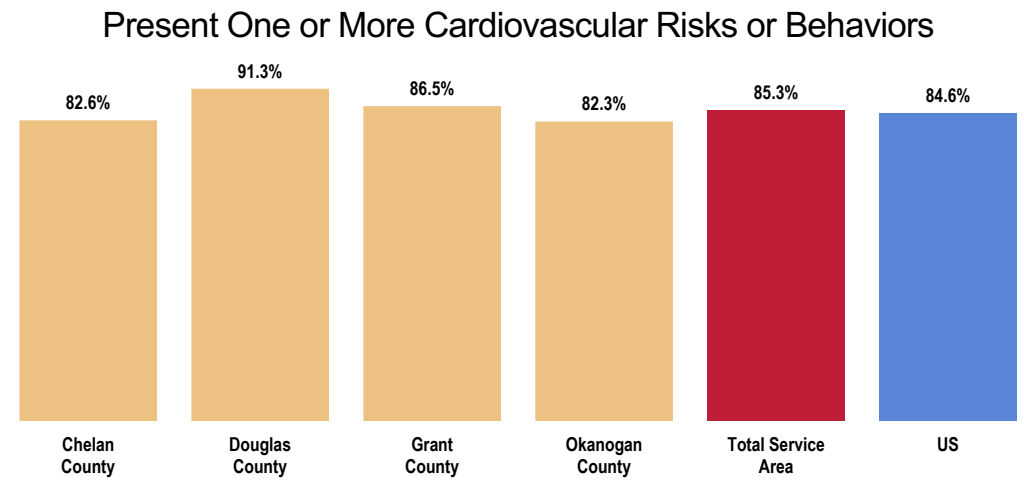
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

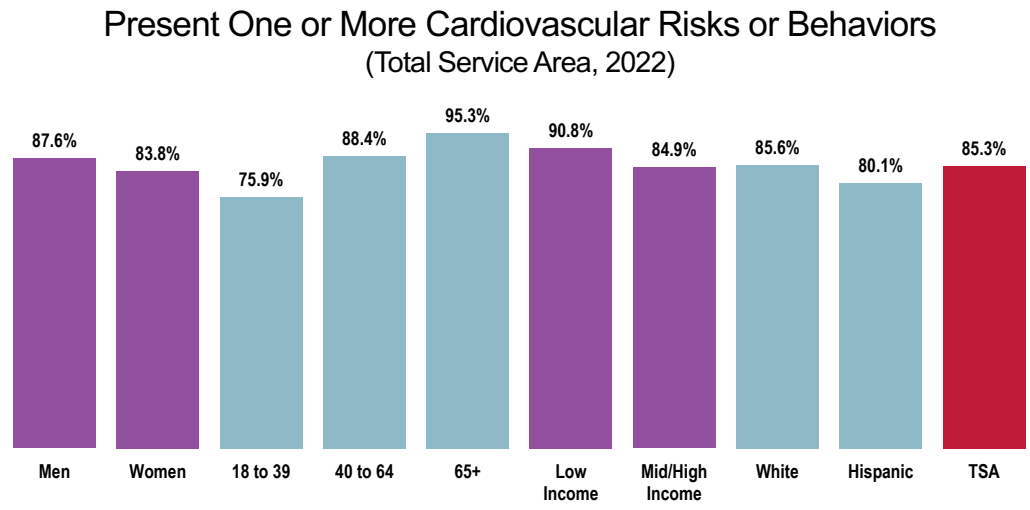
A total of 85.3% of Total Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

DISPARITY ► Significantly higher in Douglas County. Cardiovascular risk increases with age and is higher among low-income adults.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

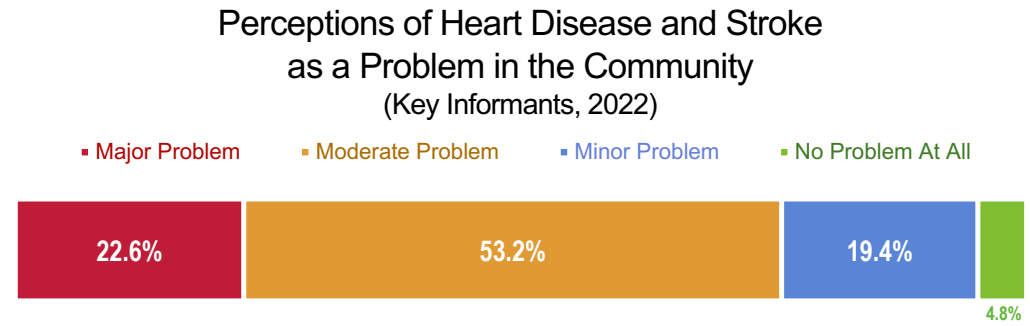
Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 115]
Notes: • Reflects all respondents.
• Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The greatest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a "moderate problem" in the community.



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Obesity

> We are an overweight and unfit society, which leads to heart disease and stroke. – Community Leader
>
> population risk factors include obesity, diabetes, tobacco use, sedentary lifestyle, poor diet, chronic stress, aging population. this is all compounded by high rate of COVID infections and the cardiovascular complications associated with it, and low uptake of COVID vaccine to prevent such complications. – Social Services Provider
>
> Obesity, unmanaged weight, lack of exercise, substance use. – Public Health Representative
>
> Heart disease and stroke have a strong connection with obesity and smoking, which seems to be prevalent in our communities. In addition, both tend to be more common in lower socioeconomic regions like ours. – Public Health Representative

Incidence/Prevalence

> Because I see lots of people impacted by this. – Community Leader
>
> Affects so many people. – Community Leader

Access to Care/Services

> Lack of resources, time, and knowledge to prevent heart disease. – Public Health Representative

Aging Population

> As people age heart disease becomes a greater risk. Studies have shown high rates of stress, substance abuse including smoking and drinking, being overweight, and a significant percentage of persons over 50. All of these factors combined with poverty that impacts availability of a healthy diet and the other factors listed above contribute to a significant problem for our population – Social Services Provider

CANCER

ABOUT CANCER

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings – such as screenings for lung, breast, cervical, and colorectal cancer – can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

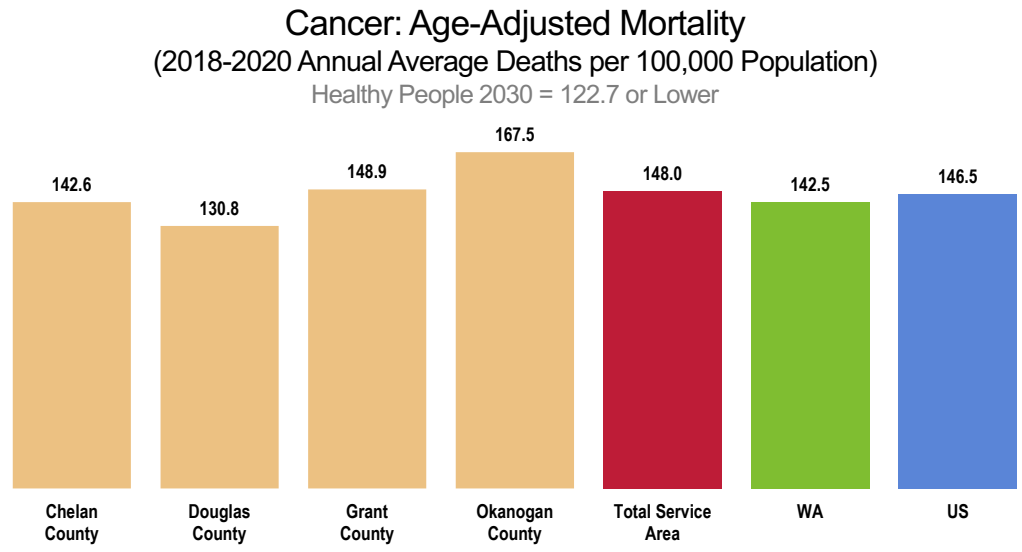
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2018 and 2020, there was an annual average age-adjusted cancer mortality rate of 148.0 deaths per 100,000 population in the Total Service Area.

BENCHMARK ▶ Fails to satisfy the Healthy People 2030 objective.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the Total Service Area.

Other leading sites include female breast cancer, prostate cancer, and colorectal cancer (both sexes).

Lung Cancer ► Fails to satisfy the related Healthy People 2030 objective.

Female Breast Cancer ► Fails to satisfy the Healthy People 2030 objective.

Colorectal Cancer ► Fails to satisfy the Healthy People 2030 objective.

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

	Total Service Area	WA	US	HP2030
ALL CANCERS	**148.0**	**142.5**	**146.5**	**122.7**
Lung Cancer	**32.4**	**30.0**	**33.4**	**25.1**
Female Breast Cancer	**22.3**	**19.1**	**19.4**	**15.3**
Prostate Cancer	**18.4**	**19.8**	**18.5**	**16.9**
Colorectal Cancer	**12.3**	**11.8**	**13.1**	**8.9**

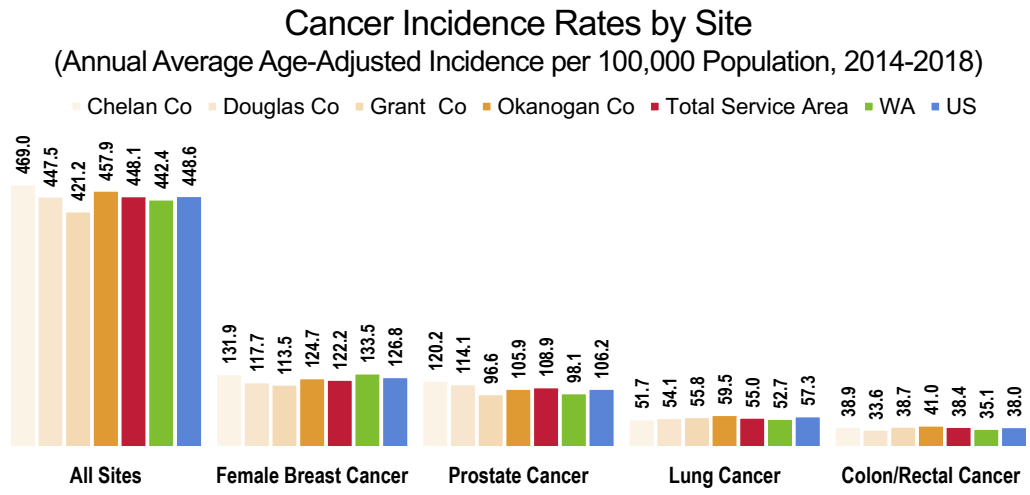
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

Cancer Incidence

The highest cancer incidence rates are for female breast cancer and prostate cancer.

DISPARITY ► Colorectal cancer incidence is significantly lower in Douglas County.



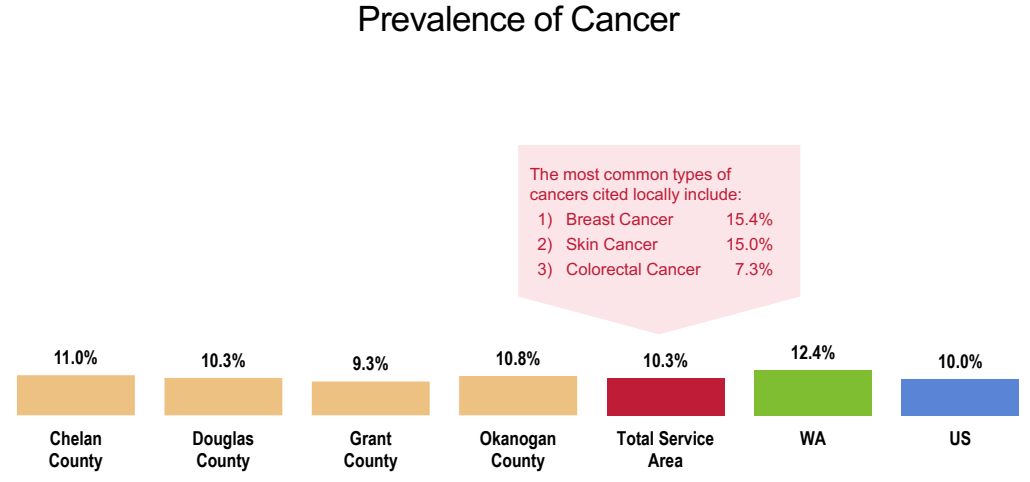
Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

A total of 10.3% of surveyed Total Service Area adults report having ever been diagnosed with cancer. The most common types include breast cancer, skin cancer, and colorectal cancer.

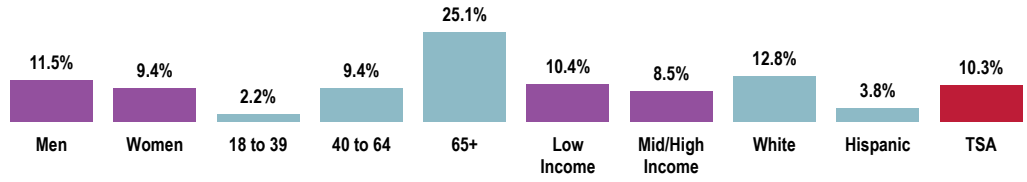
DISPARITY ► Cancer prevalence increases with age and is more commonly reported among non-Hispanic White residents.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

Prevalence of Cancer
(Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 25]
Notes: • Reflects all respondents.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
  - National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear/HPV testing); and colorectal cancer (colonoscopy/sigmoidoscopy and fecal occult blood testing).

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Cancer Screenings

Among women age 50-74, 71.9% have had a mammogram within the past 2 years.

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.

Among Total Service Area women age 21 to 65, 78.2% have had appropriate cervical cancer screening.

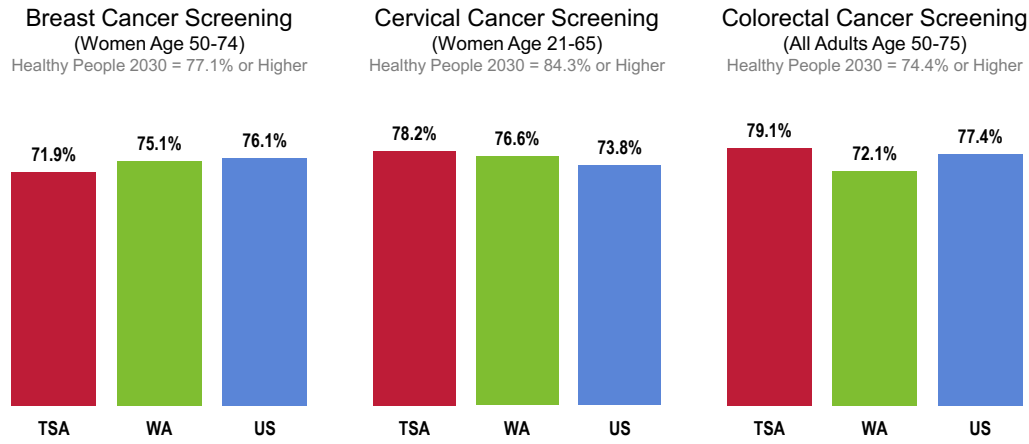
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

Among all adults age 50-75, 79.1% have had appropriate colorectal cancer screening.

BENCHMARK ► Higher than the Washington percentage. Satisfies the Healthy People 2030 objective.

DISPARITY ► Higher in Douglas County (not shown).

"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

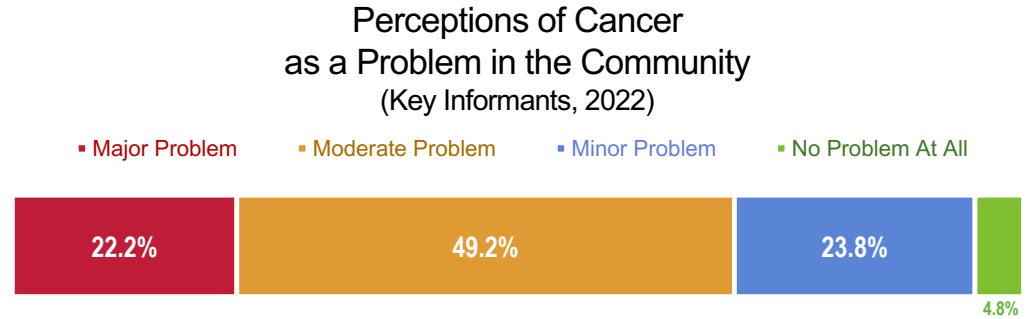


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The greatest share of key informants taking part in an online survey characterized *Cancer* as a "moderate problem" in the community.



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> It seems to be occurring at an alarming rate. – Community Leader
>
> Vital records information. – Public Health Representative
>
> Rate of incidence presented. – Other Health Provider
>
> Many people that I know have either had cancer, are battling cancer, or have loved one afflicted. – Social Services Provider
>
> It affects people across the board and all levels of income and need. – Community Leader
>
> Cancer affects so many people. Can do more with early detection, increasing the chances of survival. – Community Leader

Access to Care/Services

> I believe there are not enough resources to address the types of cancer that are happening in this community. Preventative or treatment. – Community Leader
>
> Due to the lack of treatment options in the community. – Social Services Provider

Access to Care for Uninsured/Underinsured

> 1) The population without insurance or under-insured individual often delay preventive care which will delay early cancer diagnosis. 2) The lack of timely appointments for ultrasound, colonoscopy services. 3) Un-insured and under-insured can be prevented from necessary diagnostic tests due to cost – Public Health Representative

Competition

> It is an issue due to competition for local care and consistency of physicians. – Social Services Provider

Environmental Contributors

> Only an assumption, but cancer seems more prevalent in our community and I wonder if it has to do with orchard chemicals in the valley. – Community Leader

Impact on Quality of Life

> I listed major, not because of the number of incidences, but because of the impact it has on those with the diagnosis and their families. – Community Leader

RESPIRATORY DISEASE (INCLUDING COVID-19)

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease – like reducing air pollution and helping people quit smoking – are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases – for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

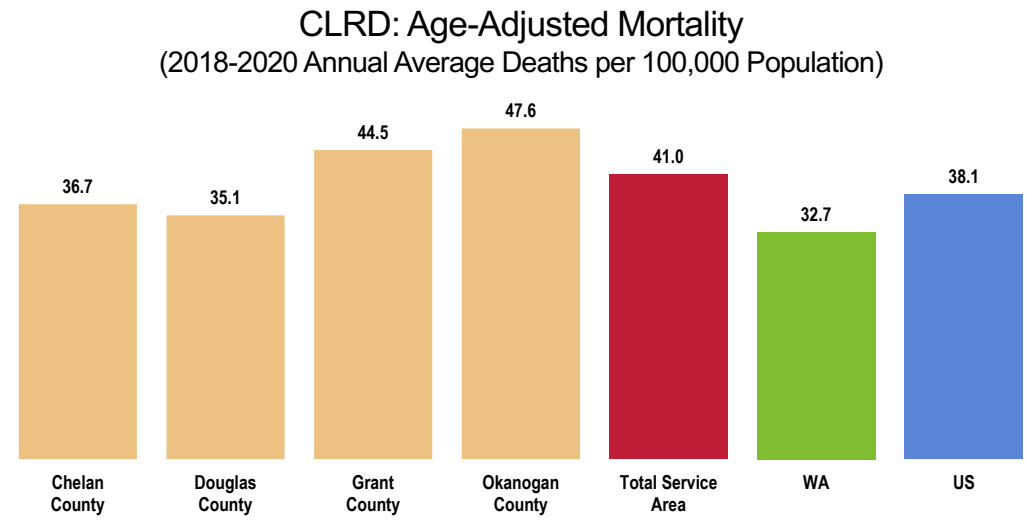
Chronic Lower Respiratory Disease Deaths (CLRD)

Note: Chronic lower respiratory disease (CLRD) includes lung diseases such as emphysema, chronic bronchitis, and asthma.

Between 2018 and 2020, there was an annual average age-adjusted CLRD mortality rate of 41.0 deaths per 100,000 population in the Total Service Area.

BENCHMARK ► Worse than the Washington mortality rate.

DISPARITY ► Lowest among Douglas County residents.



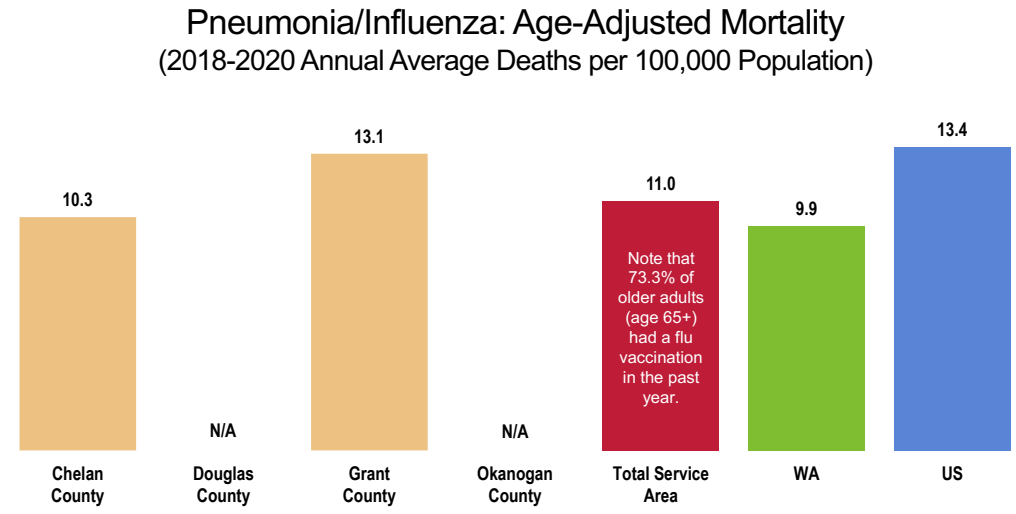
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Notes: • CLRD is chronic lower respiratory disease.

Pneumonia/Influenza Deaths

Between 2018 and 2020, the Total Service Area reported an annual average age-adjusted pneumonia influenza mortality rate of 11.0 deaths per 100,000 population.

BENCHMARK ► Lower than the US figure.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- 2022 PRC Community Health Survey, PRC, Inc. [Item 124]

Prevalence of Respiratory Disease

Asthma

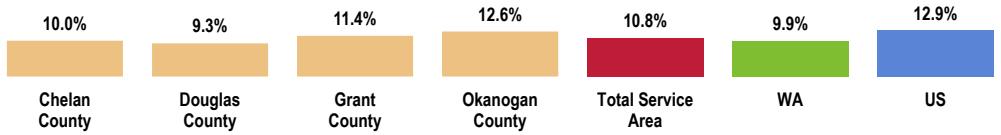
Adults

Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

A total of 10.8% of Total Service Area adults currently suffer from asthma.

DISPARITY ► Reported more often among Whites.

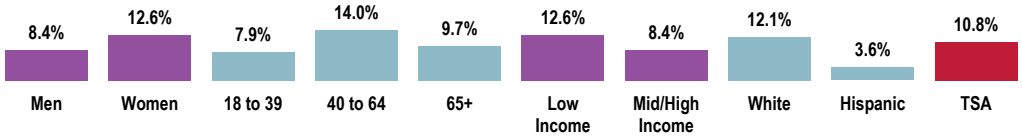
Prevalence of Asthma



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Prevalence of Asthma
(Total Service Area, 2022)



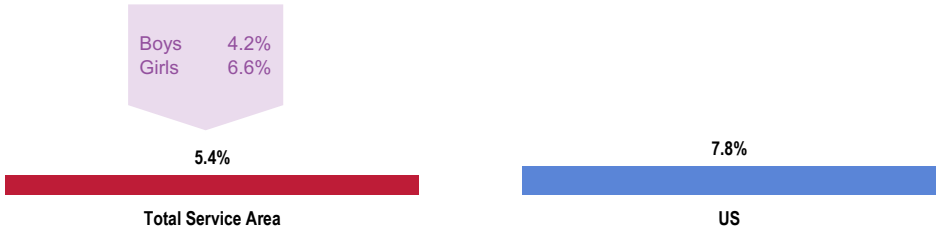
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 119]

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Children

Among Total Service Area children under age 18, 5.4% currently have asthma.

Prevalence of Asthma in Children
(Parents of Children Age 0-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 120]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

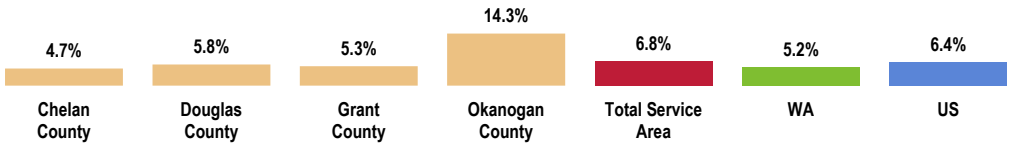
Chronic Obstructive Pulmonary Disease (COPD)

Note: COPD includes lung diseases such as emphysema and chronic bronchitis.

A total of 6.8% of Total Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

DISPARITY ► Significantly higher in Okanogan County.

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)



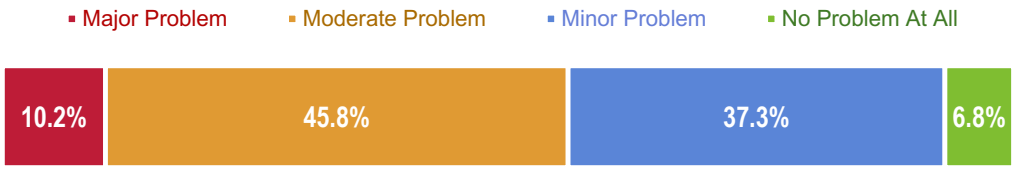
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The greatest share of key informants taking part in an online survey characterized *Respiratory Disease* as a "moderate problem" in the community.

Perceptions of Respiratory Diseases
as a Problem in the Community
(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> The long-term effects of Covid-19 and a proclivity of the population to chronic disease. – Public Health Representative
>
> Tobacco/marijuana/vaping products create problems and there is limited support to address it. – Community Leader

Environmental Contributors

> Several fire seasons contribute to chronic lung conditions due to wildfire smoke. – Public Health Representative

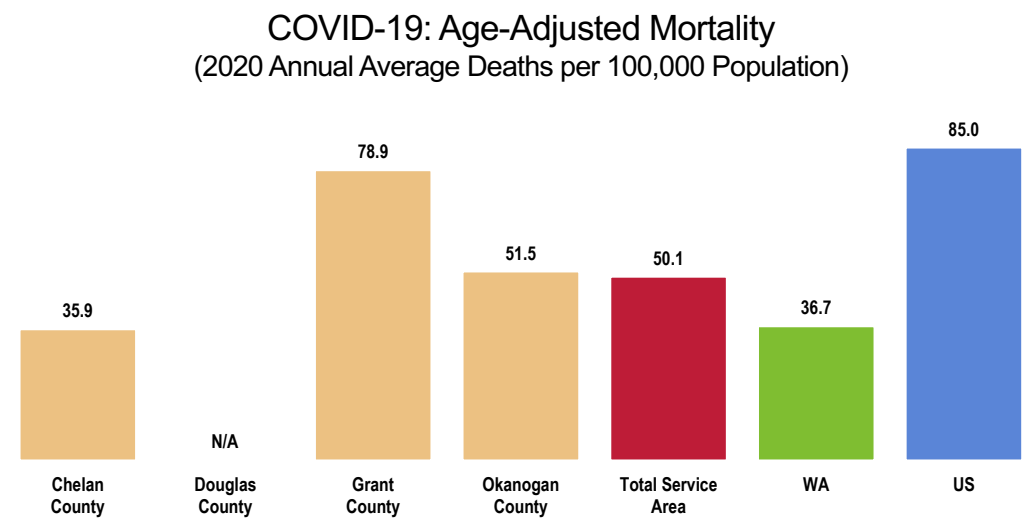
Age-Adjusted COVID-19 Deaths

COVID-19 Deaths

In 2020, there was an annual average age-adjusted COVID-19 mortality rate of 50.1 deaths per 100,000 population in the Total Service Area.

BENCHMARK ► Higher than the Washington mortality rate but much lower than the US rate.

DISPARITY ► Highest among Grant County residents (Douglas County data not available).

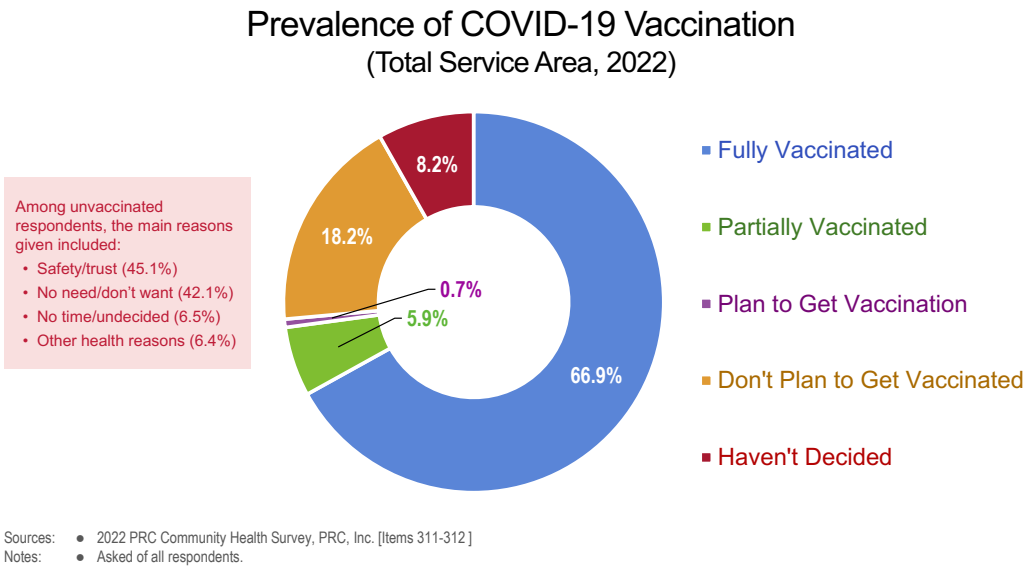


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Prevalence of COVID-19 Vaccination

In 2022, 72.8% of the Total Service Area population was fully or partially vaccinated against COVID-19.

DISPARITY ► Vaccination against COVID-19 is lowest in Grant County (not shown).



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 311-312]
Notes: • Asked of all respondents.

Adverse Changes in Health Behaviors

Surveyed adults reported a change in certain health-related behaviors and activities since the pandemic began in March 2020:

EXERCISE ► 21.0% are exercising *less often*.

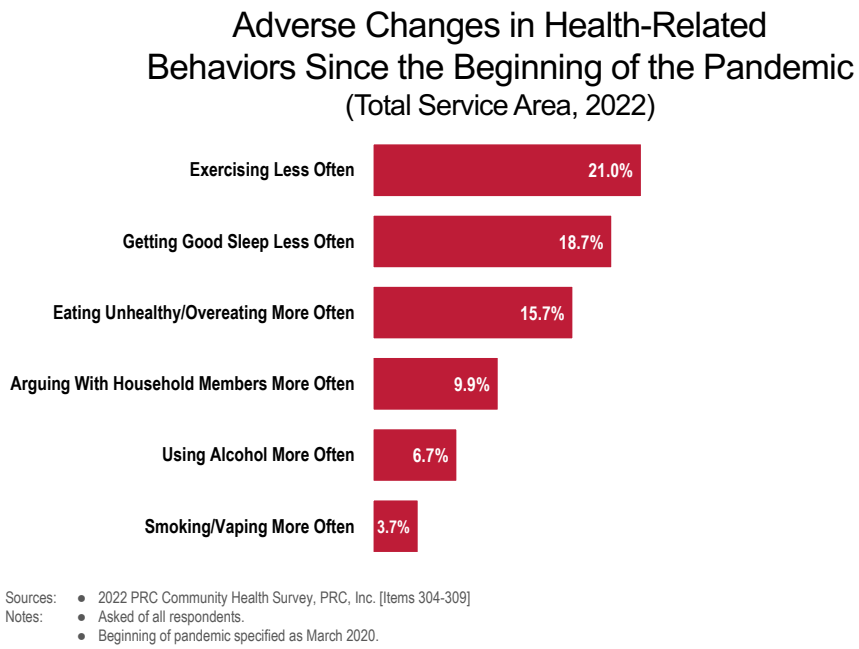
SLEEP ► 18.7% are getting good sleep *less often*.

DIETARY HABITS ► 15.7% are eating unhealthy foods or overeating *more often*.

RELATIONSHIPS ► 9.9% are arguing with household members *more often*.

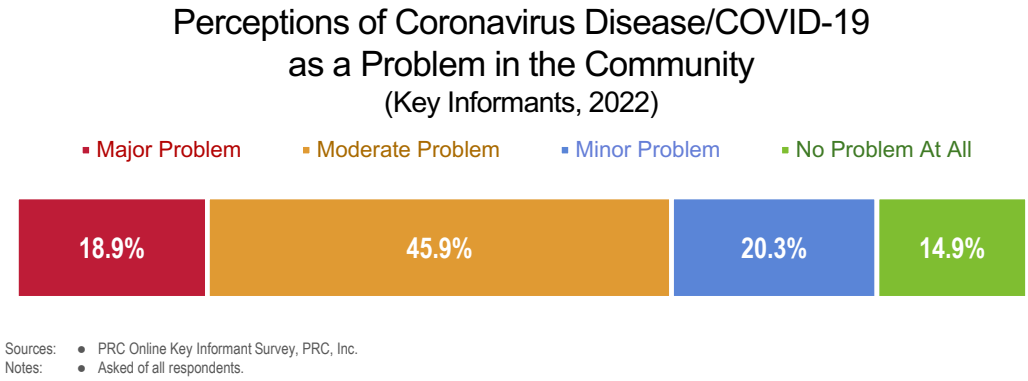
ALCOHOL USE ► 6.7% are drinking alcohol *more often*.

TOBACCO USE ► 3.7% are smoking or vaping *more often*.



Key Informant Input: Coronavirus Disease/COVID-19

The greatest share of key informants taking part in an online survey characterized *Coronavirus Disease/COVID-19* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Vaccination Coverage

> Low vaccine rate, anti-mask/anti-mandate mentality, misinformation about the vaccines and about COVID infection and consequences. The high rates of infection over the past 2 years with every surge (original, Delta, Omicron variants) has flooded the system and displaced others who need health care resources and access for non-COVID health issues. Loss of health care staff because they refused to get vaccinated has compounded the problem. – Social Services Provider
>
> Only 50% of population eligible for vaccinations have received it. – Public Health Representative
>
> Unvaccinated, government mistrust, inadequate PH resources to track and monitor. – Other Health Provider
>
> Our community maintains a low vaccination rate and compliance with masking, causing our region to be one of the highest positivity rates per 100,000 in Washington State. – Community Leader

Awareness/Education

> Our community like no other time in my lifetime is divided. Smart people have chosen to believe false information regarding vaccinees, testing and masking. It makes it really hard to navigate. In my world, you can walk into a business, and they act like COVID was a made-up political poly from our government. So the confusion for customers is huge. Also the perception that testing is hard to get. It gets exhausting for those of us tasked to lead in this time. Another problem is the access to "normal" and preventive healthcare due to COVID restrictions. – Community Leader
>
> According to the DOH we are still surging. Too many people in these counties think there is no problem. It blows my mind. Now they think that in March we don't have to wear masks anywhere. I'm gearing up for problems at a nonprofit that I run. – Community Leader
>
> Misinformation being spread. Blatant defiance from public school teachers and officials. Racism. Anti-masking in the name of "liberty" in our rural conservative area. Lack of accountability from other businesses and healthcare providers. – Social Services Provider

Impact on Quality of Life

> This has been an ongoing challenge for over two years now. It has affected the workplace and home lives of most all residents. It has sickened countless people, cause the death of others, caused job loss due to vaccination status and left healthcare facilities understaffed. The created additional challenges with compensation and burnout. – Community Leader
>
> The reaction to the disease will have a major future effect on school and preschool children. Politics and mandates are a major contributor to this being a problem. – Community Leader
>
> It has taken over our entire lives. It is a major problem because all of the restrictions impact everything that we do. Hospitalizations are still up and people are still getting sick. – Community Leader

Incidence/Prevalence

> Numbers from DOH and CH have been eye-opening. By the looks of it, the numbers are dropping at least for those that are vaccinated. – Community Leader
>
> The numbers of people infected and its impact on ability of businesses to remain open. – Social Services Provider

Lack of Adherence to Safety Measures

> Although cases decreasing, noncompliance to masking, continuous messaging by anti-government people, and general attitude of the population contribute to the ongoing problem. – Other Health Provider

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

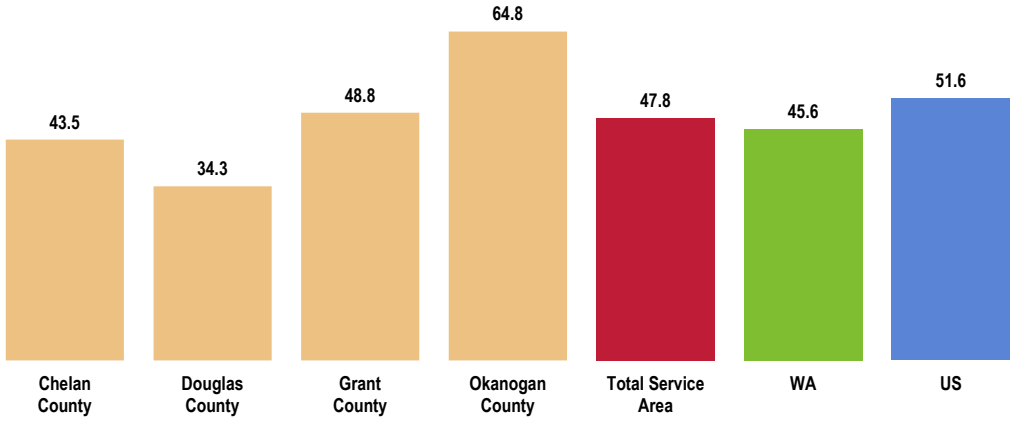
Between 2018 and 2020, there was an annual average age-adjusted unintentional injury mortality rate of 47.8 deaths per 100,000 population in the Total Service Area.

DISPARITY ► Much higher in Okanogan County.

Unintentional Injuries: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

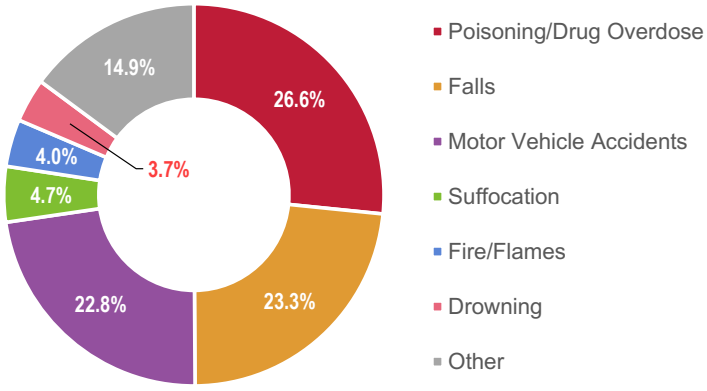
Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Poisoning (including unintentional drug overdose), falls, and motor vehicle accidents accounted for most unintentional injury deaths in the Total Service Area between 2018 and 2020.

Leading Causes of Unintentional Injury Deaths

(Total Service Area, 2018-2020)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Intentional Injury (Violence)

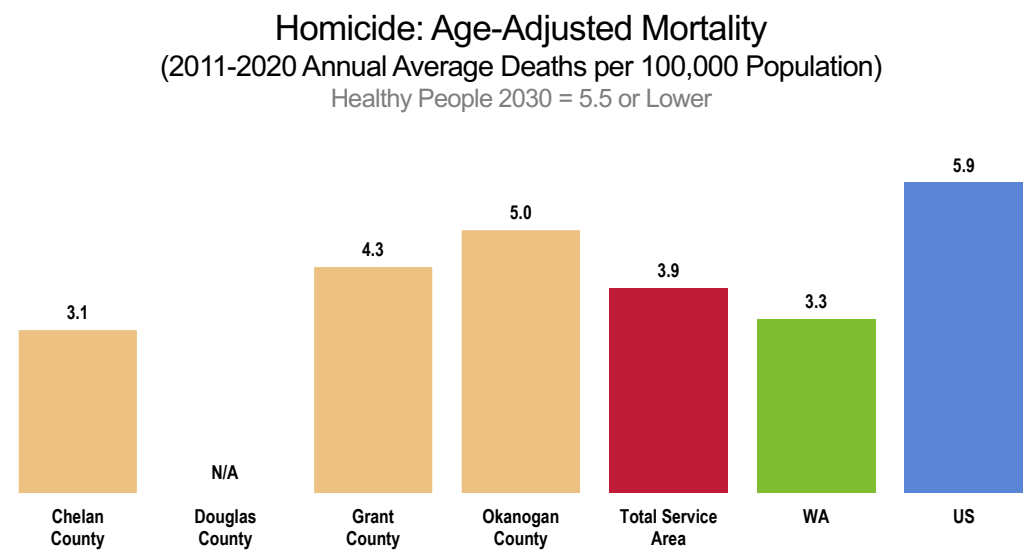
Age-Adjusted Homicide Deaths

The Total Service Area reported 3.9 homicides per 100,000 population during the 2018-2020 reporting period (age-adjusted death rate).

BENCHMARK ► Higher than the state rate but lower than the US rate. Satisfies the Healthy People 2030 objective.

DISPARITY ► The homicide rate is lowest in Chelan County.

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Violent Crime

Violent Crime Rates

Between 2014 and 2016, there were a reported 211.1 violent crimes per 100,000 population in the Total Service Area.

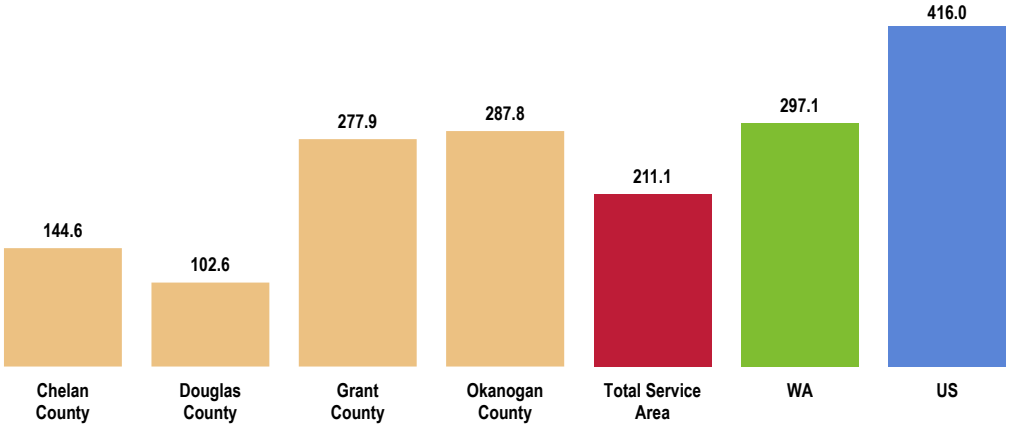
BENCHMARK ► Lower than the state and national rates.

DISPARITY ► Significantly higher in Grant and Okanogan Counties.

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime
(Rate per 100,000 Population, 2014-2016)



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

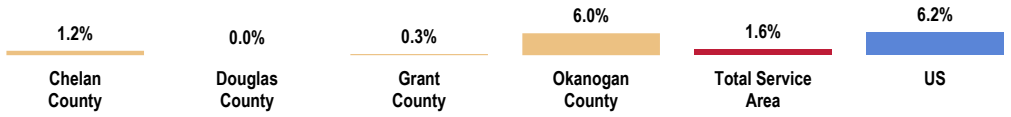
Community Violence

A total of 1.6% of surveyed Total Service Area adults acknowledge being the victim of a violent crime in the area in the past five years.

BENCHMARK ► Much lower than the US percentage.

DISPARITY ► Significantly higher in Okanogan County.

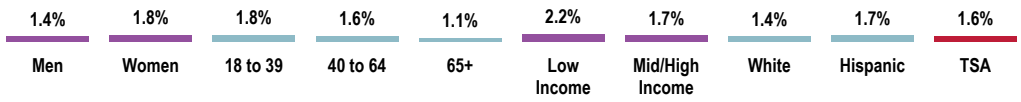
Victim of a Violent Crime in the Past Five Years



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Victim of a Violent Crime in the Past Five Years
(Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
Notes: • Asked of all respondents.

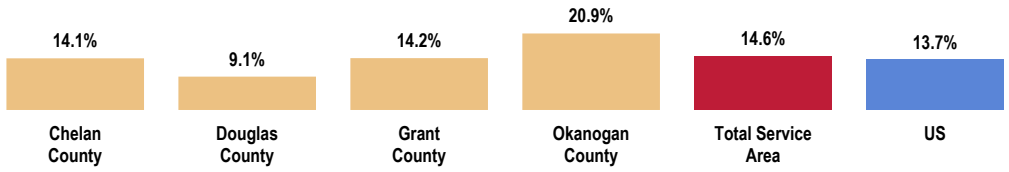
Family Violence

Respondents were read: "By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

A total of 14.6% of Total Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

DISPARITY ► Unfavorably high in Okanogan County.

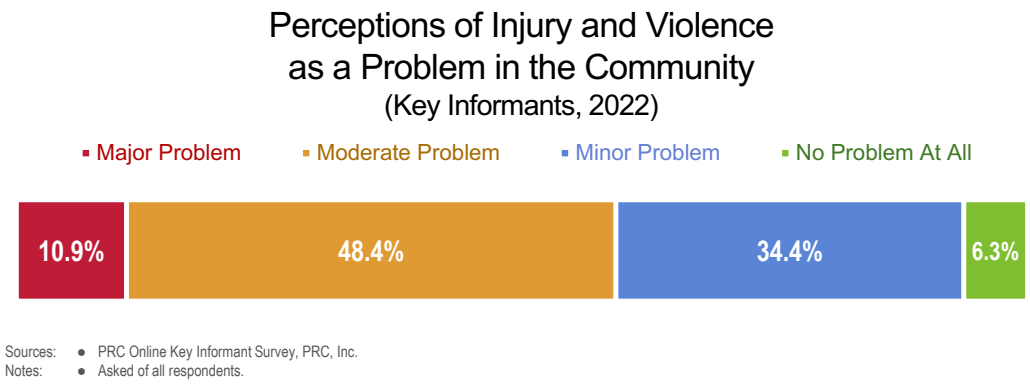
Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 39]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a "moderate problem" in the community.



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Having worked with many clients affected by injury and violence, I believe this to be a major problem. A lack of repercussions to the offender make them more likely to repeat as well. – Social Services Provider
>
> Domestic violence impacts the entire family unit – teaching young children that violence is how to release frustration and solve issues. Other injury impacts stem from drug abuse and crime. Occupational injuries are frequent due to the local agricultural economy. – Social Services Provider
>
> Rural injuries. Domestic violence. Substance use/abuse. – Public Health Representative

Access to Care/Services

> There are not enough emergency responders who are trained in identifying DV or IPV. – Community Leader

Alcohol/Drug Use

> Substance use and mental health needs are major concerns in North Central. These issues can lead to self-injury, specifically with increased suicide risk, as well as violence associated with substance use. – Other Health Provider

Denial/Stigma

> There are many people in our counties that believe that crime or especially violent crime doesn't happen in our area, and if it does it doesn't happen to people "like us". This causes more shame for people to face when they are reporting these types of activities. – Social Services Provider

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

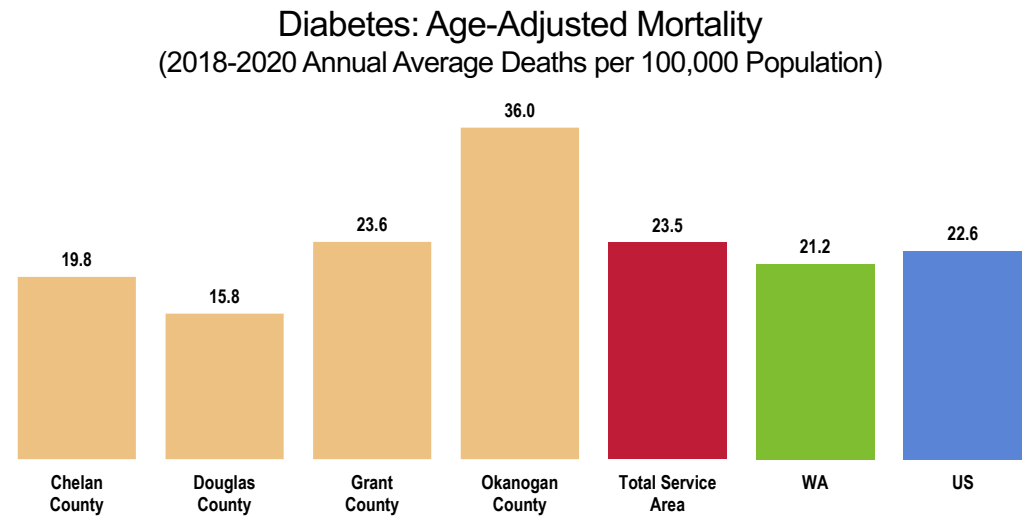
Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Between 2018 and 2020, there was an annual average age-adjusted diabetes mortality rate of 23.5 deaths per 100,000 population in the Total Service Area.

DISPARITY ► The mortality rate is dramatically higher in Okanogan County.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Prevalence of Diabetes

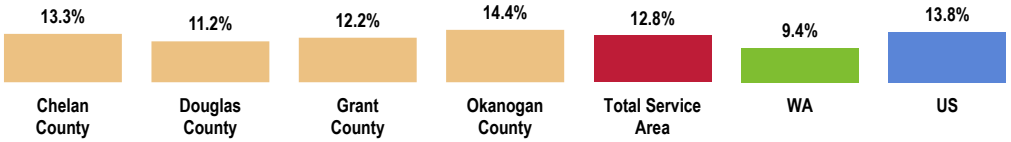
A total of 12.8% of Total Service Area adults report having been diagnosed with diabetes.

BENCHMARK ► Significantly higher than the Washington percentage.

DISPARITY ► The prevalence increases with age and is more often reported among low-income residents.

Prevalence of Diabetes

Another 8.3% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

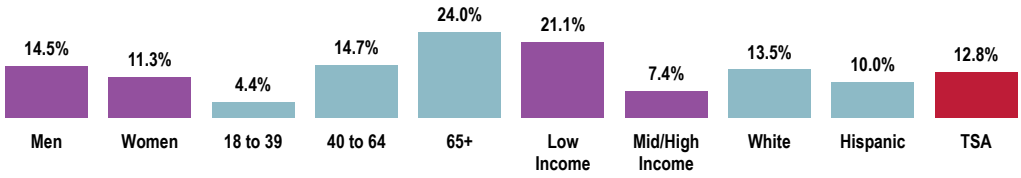


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 121]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Diabetes
(Total Service Area, 2022)

Note that among adults who have not been diagnosed with diabetes, 36.7% report having had their blood sugar level tested within the past three years.

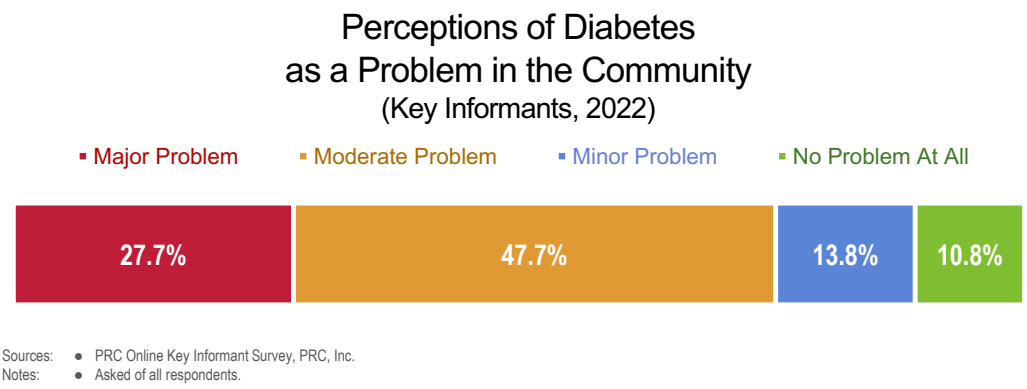


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 33, 121]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

A high percentage of key informants taking part in an online survey characterized *Diabetes* as a "moderate problem" in the community.



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Prevention education for diabetes care. I know LOTS of people who are pre-diabetic and diabetic. Some of them are using insulin. My concern is the diabetes epidemic and the lack of education for what is, in MANY cases, a PREVENTABLE DISEASE! Lunches in the schools set our children up for diabetes. The lack of solid nutritional information is mind-boggling to me. – Community Leader
>
> Combination of education (lack of knowledge about nutrition), sedentary workday and sedentary lifestyle outside of work hours. – Community Leader
>
> Access to nutritional counseling, lifestyle, obesity, high blood pressure. – Public Health Representative
>
> Lack of education about nutrition and access to physical exercise during period of extreme heat and cold. Poor diet and lack of exercise often lead to weight gain and diabetes. Drugs are prescribed that have terrible side effects rather than examining alternative natural medicine, diet, and affordable exercise instruction that is covered by health insurance and Medicaid/Medicare – Social Services Provider
>
> Emphasis on education in early detection of the disease appears to be lacking and is critical to getting people on the right path to management of this condition. – Community Leader
>
> Lack of resources for individuals to learn how to care for themselves and resources to purchase supplies and fresh foods. – Public Health Representative
>
> Getting information from healthcare providers about insurance-sponsored programs available. – Community Leader

Income/Poverty

> Poverty means that people cannot afford foods that support healthy diet; we have a healthy food desert. Lack of adequate physical activity related to work schedules (need to work to support families), limited options for exercise that are accessible. Cultural—foods are high in carbs and fat, quantities excessive, celebrations center around food and drink. Heredity—predisposition to diabetes. Health care access—cost of best and newest medications to treat diabetes is very expensive and not covered well by insurance and are unaffordable for those that lack insurance. – Social Services Provider

Affordable Medications/Supplies

> Cost of medications. – Social Services Provider
>
> Access to affordable insulin. – Community Leader

Disease Management

> Following physician instructions. – Other Health Provider
>
> Adhering to the necessary diet and medicine regimen to keep it under control. – Community Leader

Obesity

> Obesity as risk for diabetes is a problem throughout the community. Education regarding the prevention and treatment of diabetes is not seen as a priority by residents. – Community Leader

Access to Affordable Healthy Food

> Being able to afford food that is healthy, such as fresh fruits and vegetables. – Public Health Representative

Diagnosis/Treatment

> Detection and ability to manage with diet. – Community Leader

Lifestyle

> A healthy lifestyle to avoid it. – Community Leader

KIDNEY DISEASE

ABOUT KIDNEY DISEASE

More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke – and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

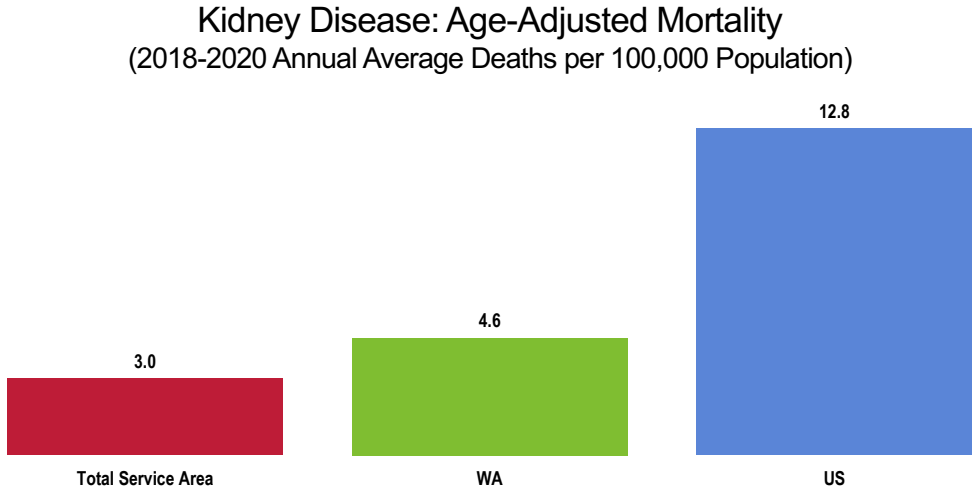
Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

Between 2018 and 2020, there was an annual average age-adjusted kidney disease mortality rate of 3.0 deaths per 100,000 population in the Total Service Area.

BENCHMARK ► Below the Washington mortality rate and especially the US rate.



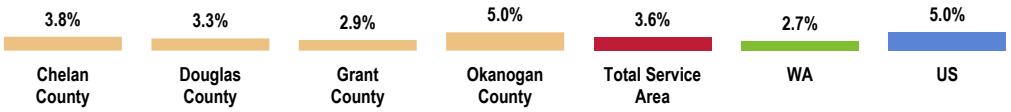
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Prevalence of Kidney Disease

A total of 3.6% of Total Service Area adults report having been diagnosed with kidney disease.

DISPARITY ▶ Strong correlation with age.

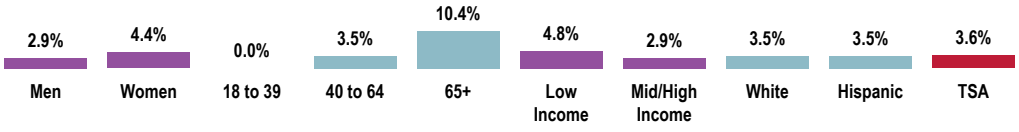
Prevalence of Kidney Disease



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Kidney Disease
(Total Service Area, 2022)

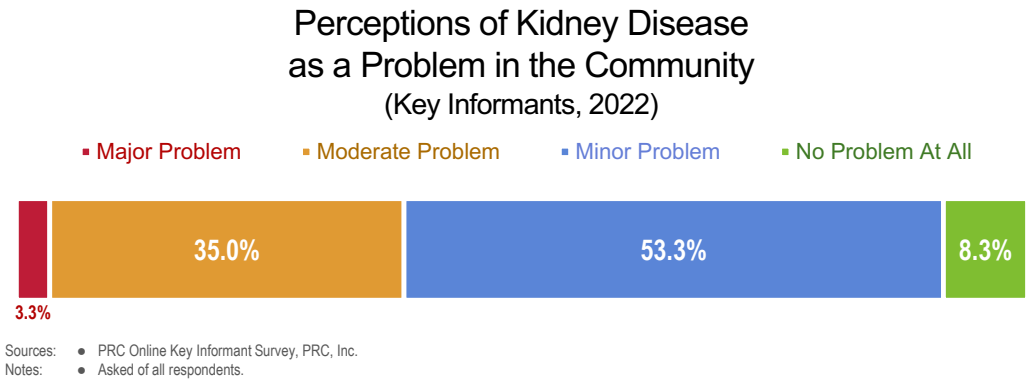


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 24]

Notes:
- Asked of all respondents.

Key Informant Input: Kidney Disease

Key informants taking part in an online survey generally characterized *Kidney Disease* as a "minor problem" in the community.



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

POTENTIALLY DISABLING CONDITIONS

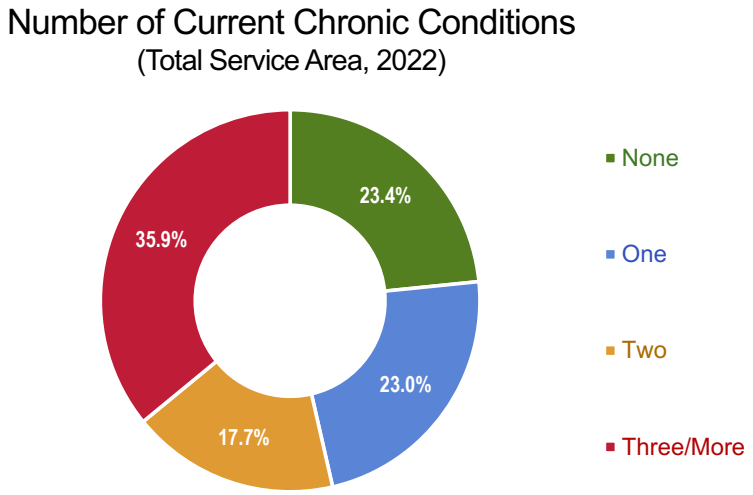
Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.

Among Total Service Area survey respondents, most report currently having at least one chronic health condition.

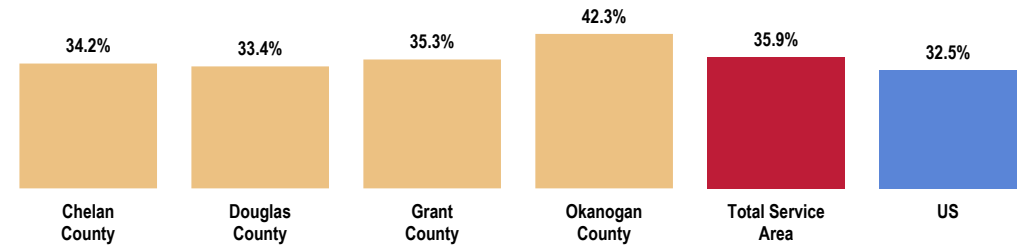


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

In fact, 35.9% of Total Service Area adults report having three or more chronic conditions.

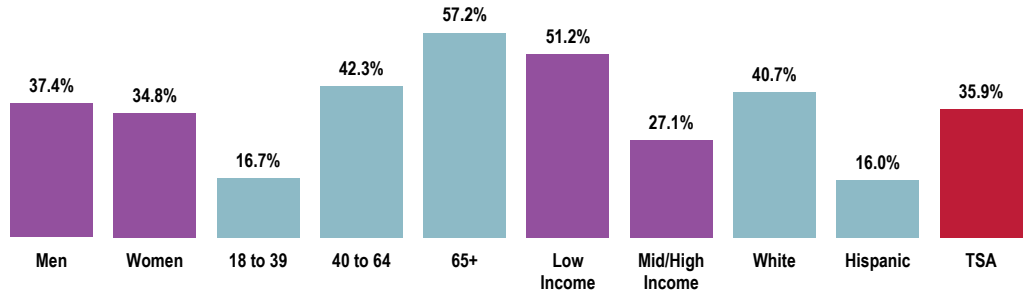
DISPARITY ► Strong correlation with age, and reported more often among lower-income and non-Hispanic White residents.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: • Asked of all respondents.
• In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

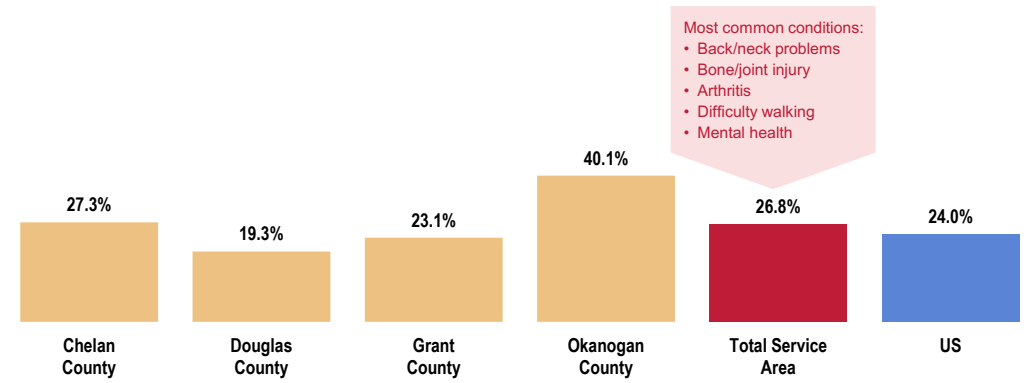
– Healthy People 2030 (https://health.gov/healthypeople)

Activity Limitations

A total of 26.8% of Total Service Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

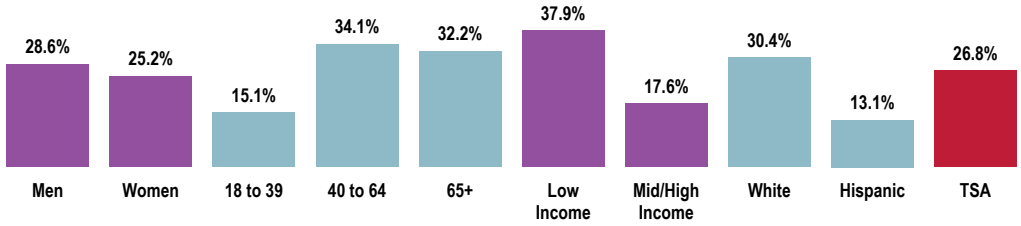
DISPARITY ► Significantly higher in Okanogan County. Activity limitations are reported more often among adults 40 and older, lower-income residents, and non-Hispanic White residents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 96-97]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem
(Total Service Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: ● Asked of all respondents.

Chronic Pain

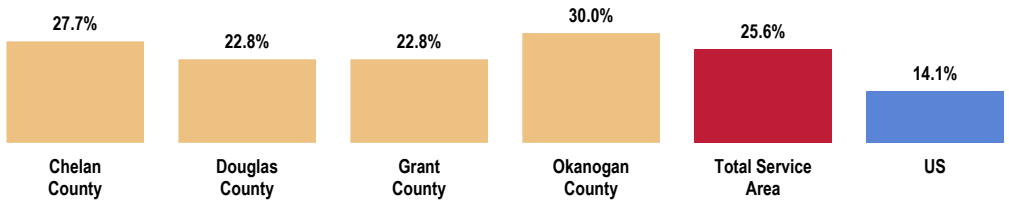
A total of 25.6% of Total Service Area adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities "every day" or "most days" during the past six months.

BENCHMARK ► Much higher than the US finding. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► More often reported by adults 40 and older, as well as lower-income and non-Hispanic White residents.

Experience High-Impact Chronic Pain

Healthy People 2030 = 7.0% or Lower



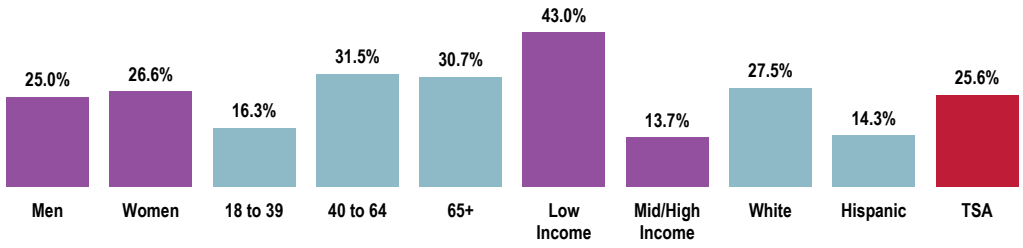
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Experience High-Impact Chronic Pain

(Total Service Area, 2022)

Healthy People 2030 = 7.0% or Lower

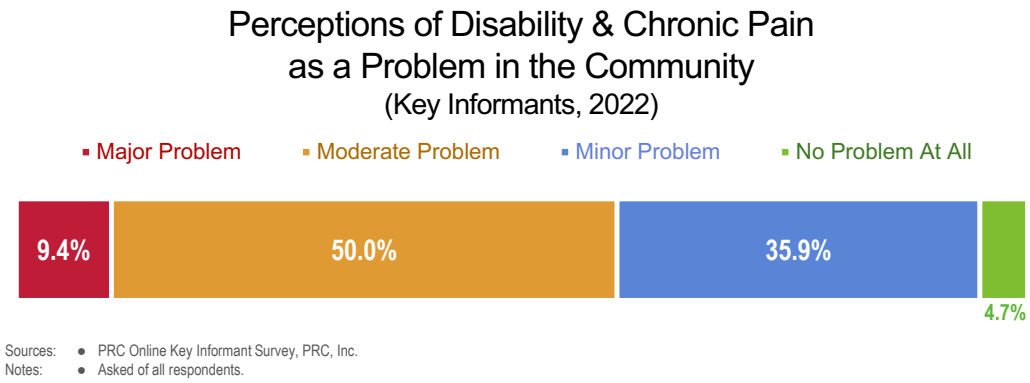


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Key Informant Input: Disability & Chronic Pain

Key informants taking part in an online survey most often characterized *Disability & Chronic Pain* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access to services that don't lead to dependency as well as isolation of the patient are difficult to reach for many of our low-income community members. even services and programs within the county can be difficult to reach if you live in Havillah and have to get a ride to Omak in the middle of winter or summer. pain leads to depression and depression tends to spiral down making the pain even worse. For example, a person with a broken wrist suddenly finds that they cannot drive, cook, or do most of the parts of daily self-care. Without help, domestic settings tend to lean into clutter and dirt and there is a helplessness about how to correct it. Instead, increasing home health visits, and engaging in groups that are access either virtually or in person with the help of a van service can change a patient's view of their existence and save them from loneliness and depression. – Social Services Provider

Aging Population

> We have an aging population, and diseases associated with aging can cause a significant amount of disability and pain. The counties covered have many communities where residents are not very healthy: obesity leads to many chronic disabilities accompanied by pain. We have a high incidence of obesity in our region. – Public Health Representative

Diagnosis/Treatment

> There are few accommodations and few options for alternative treatments for those who suffer from disability and chronic pain. Integrated medicine is out of reach for many who are indigent with these issues. The health care system treats them in a vacuum. – Social Services Provider

Income/Poverty

> We live in a high poverty and low education community. Lots of adverse childhood experiences, ongoing mental health issues impact one's ability to cope with stress, pain. Agricultural industry is a major employer– workers at high risk for acute injury, chronic occupational injury and disease, and do not have access to job retraining, language acquisition, adult education, to make career changes. Disability is accepted as an alternative income source when one's ability to work in a limited field has been exhausted and relocation is impossible. – Social Services Provider

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline – including memory loss – are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

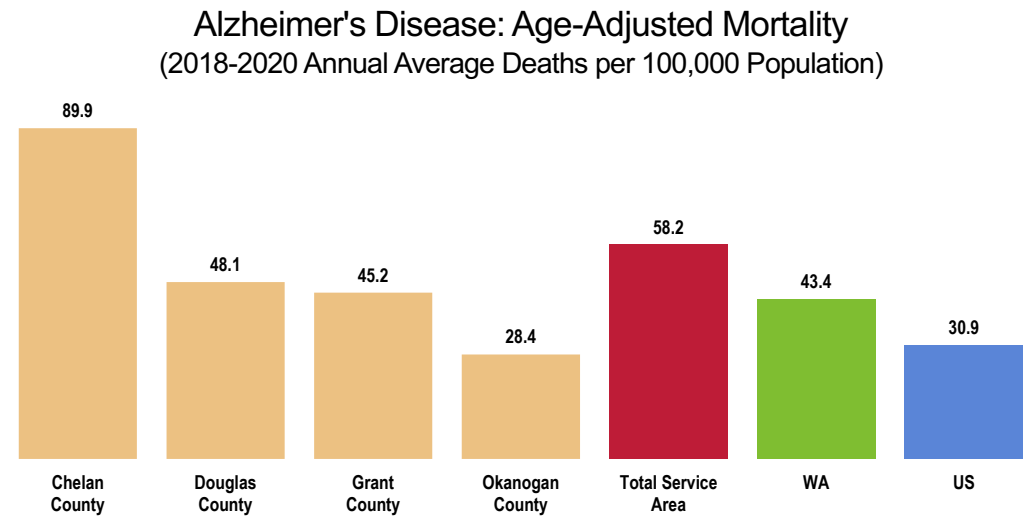
Alzheimer's Disease

Age-Adjusted Alzheimer's Disease Deaths

Between 2018 and 2020, there was an annual average age-adjusted Alzheimer's disease mortality rate of 58.2 deaths per 100,000 population in the Total Service Area.

BENCHMARK ► Well above the state and US mortality rates.

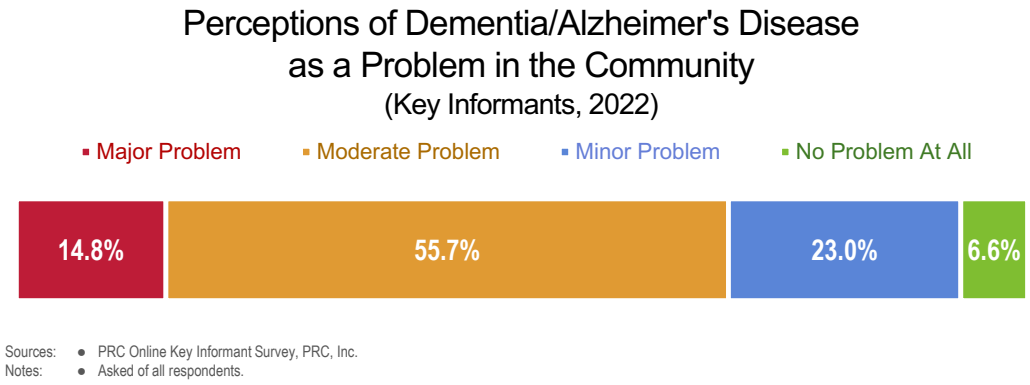
DISPARITY ► Especially high among residents of Chelan County.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Key Informant Input: Dementia/Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *Dementia/ Alzheimer's Disease* as a "moderate problem" in the community.



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> There are absolutely not enough facilities and services to address the amount of folks who are experiencing dementia/Alzheimer's disease. If the person with the diagnosis doesn't have sufficient private funds, or any dual diagnosis, there are no options in this community. Navigating in-home care and services is an incredibly difficult maze and asking someone who already is experiencing diminishing capacity to navigate that on their own is cruel. – Community Leader
>
> Due to the lack of available treatment options. – Social Services Provider
>
> Few facilities that can handle these patients. Many at home with limited resources. – Community Leader
>
> I feel like there is a lack of resources for older people who have dementia/Alzheimer's disease, or the resources that are there are difficult to navigate. – Community Leader

Access for Medicare/Medicaid Patients

> It is a problem everywhere, but our community does not have enough care facilities that will take Medicare patients. This means that many families have to try and provide care even though they are not fully qualified to do so. – Social Services Provider

Aging Population

> The counties included in the survey have an aging population, and memory loss commonly occurs as people age. Much of the older population in our region lives in rural areas where caregiving support and resources are limited. Often family members or friends end up taking care of loved ones, which can create major stress and challenges. – Public Health Representative

Impact on Caregivers/Families

> The care of individuals is a huge burden for responsible family members as victims of this disease decline. Professional care is hugely expensive, so in-home care is usually the option for those that lack financial resources. Cost of outside options far exceed the average annual income of families in the region. – Community Leader

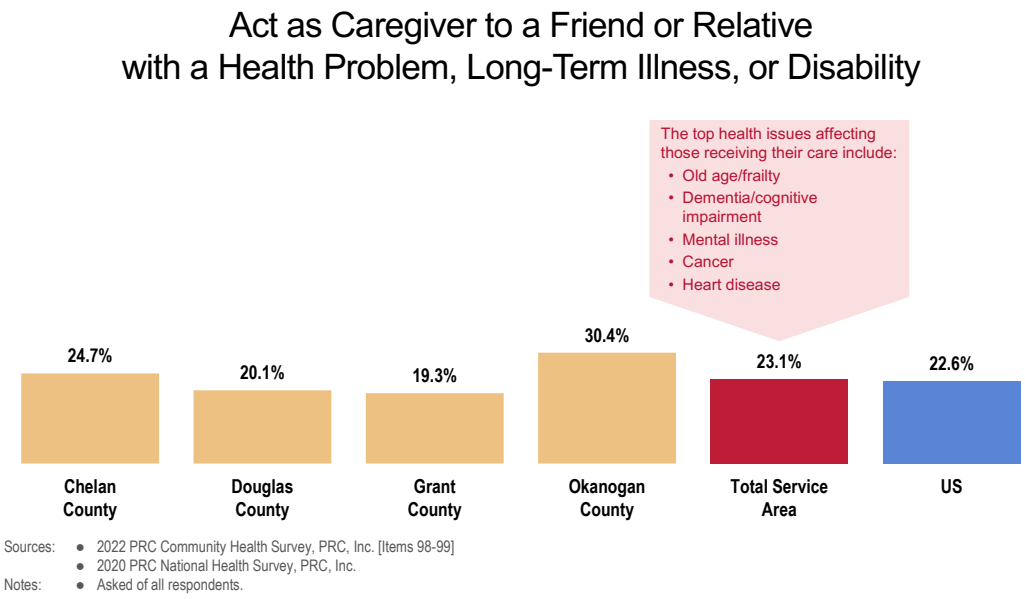
Incidence/Prevalence

> We see these patients through the emergency room. – Other Health Provider

Caregiving

A total of 23.1% of Total Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

DISPARITY ► Unfavorably high in Okanogan County.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 98-99]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

BIRTHS

BIRTH OUTCOMES & RISKS

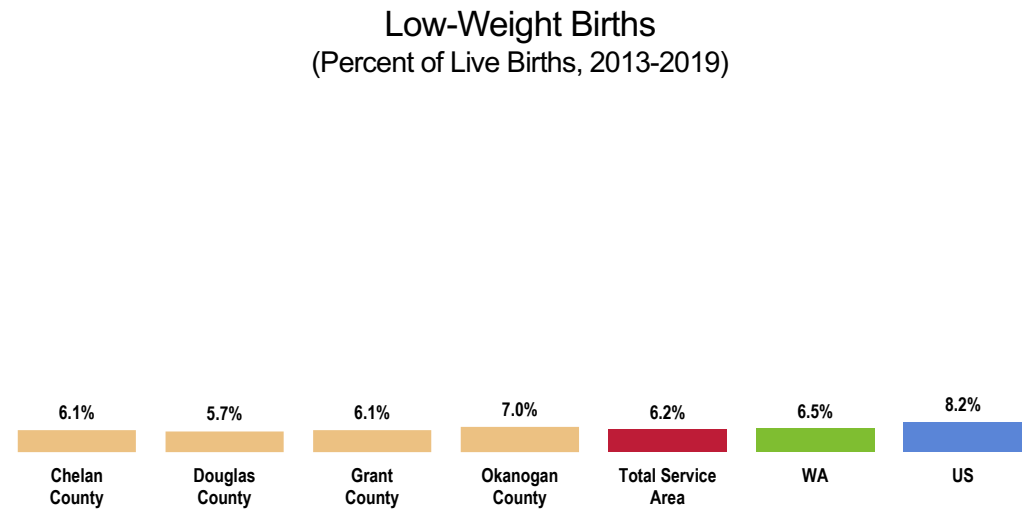
Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 6.2% of 2013-2019 Total Service Area births were low-weight.

BENCHMARK ► Lower than the national finding.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.

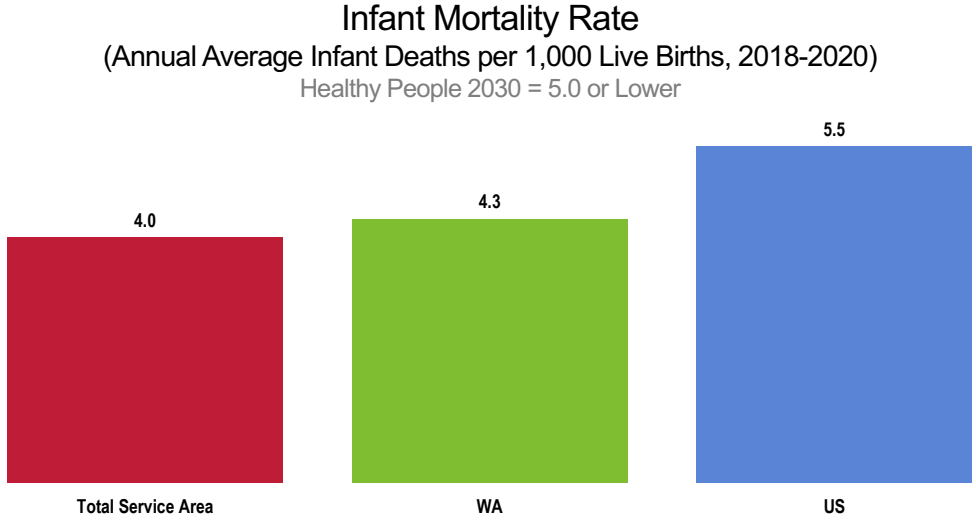
Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

Between 2018 and 2020, there was an annual average of 4.0 infant deaths per 1,000 live births.

BENCHMARK ► Lower than the national rate and satisfies the Healthy People 2030 objective.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

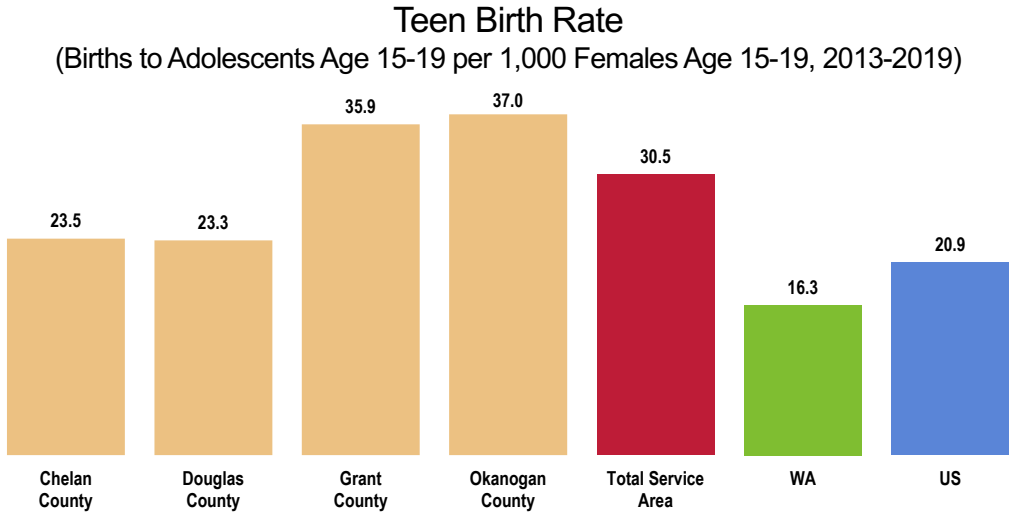
– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Between 2013 and 2019, there were 30.5 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the Total Service Area.

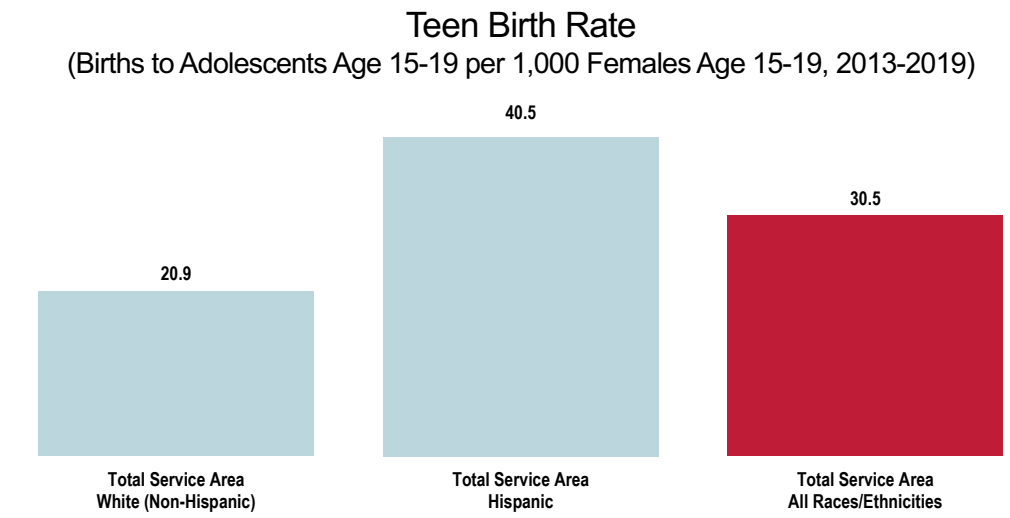
BENCHMARK ► Higher than the Washington and US findings.

DISPARITY ► Significantly higher in Grant and Okanogan Counties. More often reported in the Hispanic community.



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

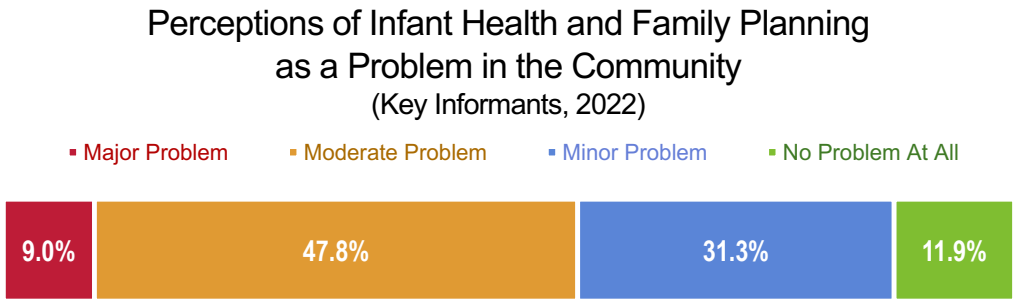


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

Key informants taking part in an online survey largely characterized *Infant Health & Family Planning* as a "moderate problem" in the community.



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access to infant health and family planning are not accessible for underserved communities but additionally there is a lot of stigma in asking for help or asking for resources. Need programs/services that are culturally appropriate or recognize that this type of education and information is new information to many residents i.e., it is not something that is discussed in family units or school. – Community Leader
>
> Prenatal care, pregnant teens; many struggling with substance abuse are not accessing this service. Nurse Family Partnership and others are not getting the referrals they need. – Social Services Provider
>
> No established midwife, doula, or birth center access here. I'm also worried about Planned Parenthood and women's access to family planning in today's political and social climate. – Community Leader

Contributing Factors

> Neonatal abstinence syndrome (substance use by mother/father). Lack of prenatal home visiting programs. Lack of family planning. – Public Health Representative
>
> In North Central, there are a significant number of migrant women who give birth without medical insurance. Overall, we believe adequate prenatal and postnatal care are critical health services for mothers and infants. – Other Health Provider

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods – like foods high in saturated fat and added sugars – are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

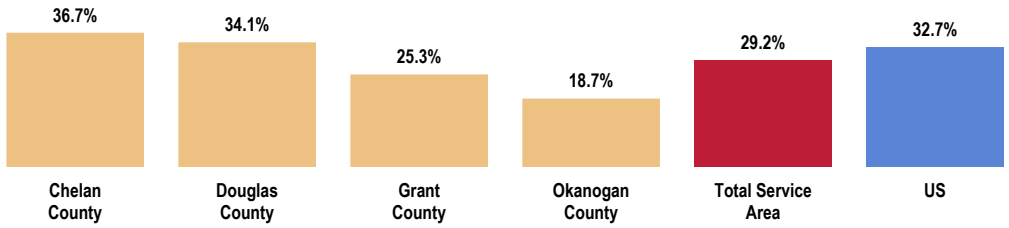
Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

A total of 29.2% of Total Service Area adults report eating five or more servings of fruits and/or vegetables per day.

DISPARITY ► Unfavorably low in Okanogan County.

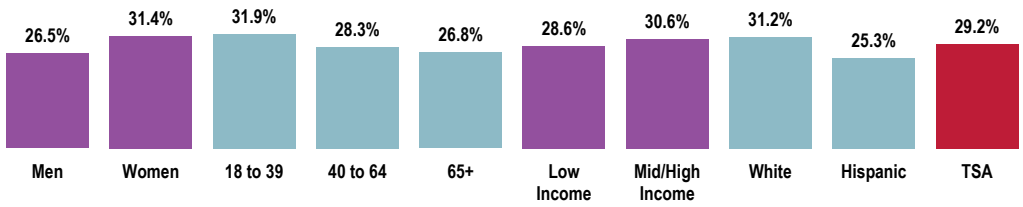
Consume Five or More Servings of Fruits/Vegetables Per Day



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 125]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Consume Five or More Servings of Fruits/Vegetables Per Day
(Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 125]
Notes: • Asked of all respondents.
• For this issue, respondents were asked to recall their food intake on the previous day.

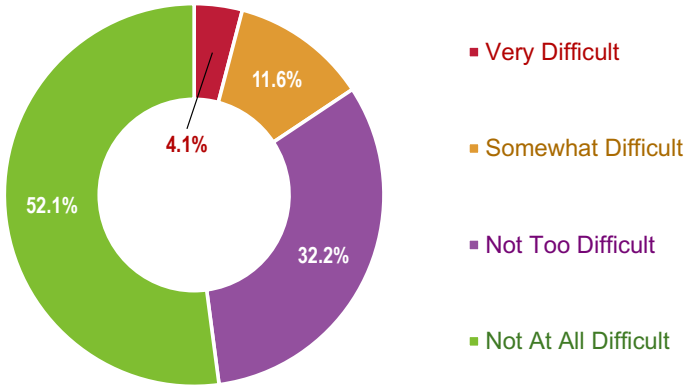
Difficulty Accessing Fresh Produce

Most Total Service Area adults report little or no difficulty buying fresh produce at a price they can afford.

Respondents were asked: "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

RELATED ISSUE
See also *Food Access* in the **Social Determinants of Health** section of this report.

Level of Difficulty Finding Fresh Produce at an Affordable Price
(Total Service Area, 2022)



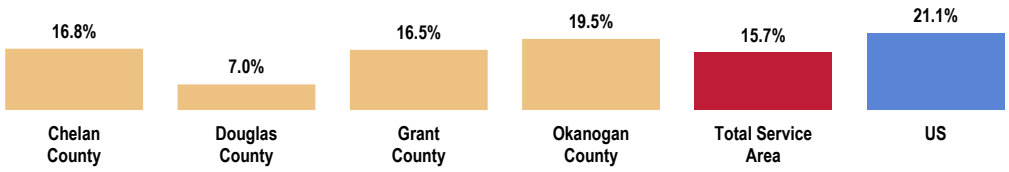
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: • Asked of all respondents.

However, 15.7% of Total Service Area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

BENCHMARK ► Better (lower) than the US percentage.

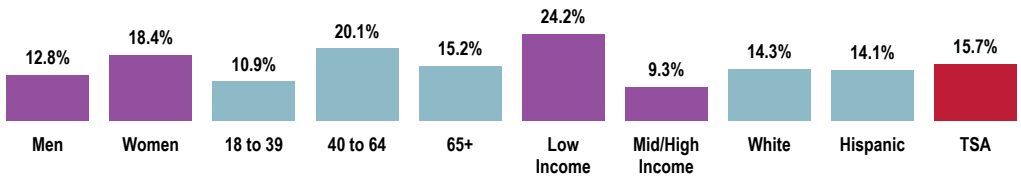
DISPARITY ► Lowest in Douglas County. Those more likely to report difficulty finding affordable produce include women, adults aged 40 to 64, and lower-income residents.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(Total Service Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active – like providing access to community facilities and programs – can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

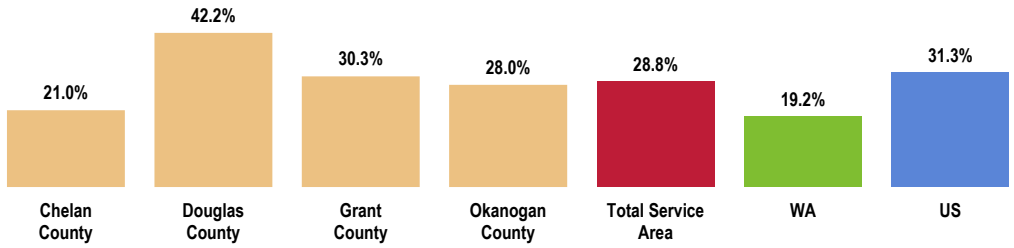
A total of 28.8% of Total Service Area adults report no leisure-time physical activity in the past month.

BENCHMARK ► Higher than the Washington percentage. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Unfavorably high in Douglas County.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Activity Levels

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Adults

A total of 24.2% of Total Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

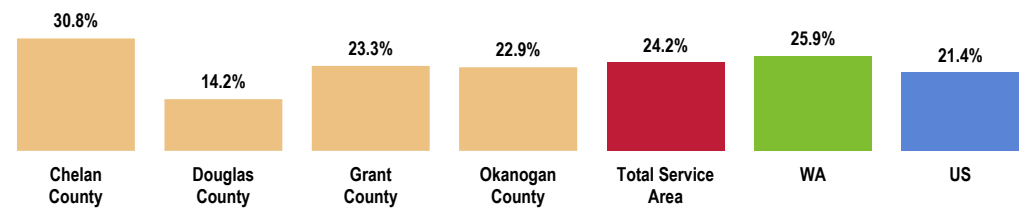
BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Unfavorably low in Douglas County. Women and residents age 40 and older are significantly less likely to meet physical activity guidelines.

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

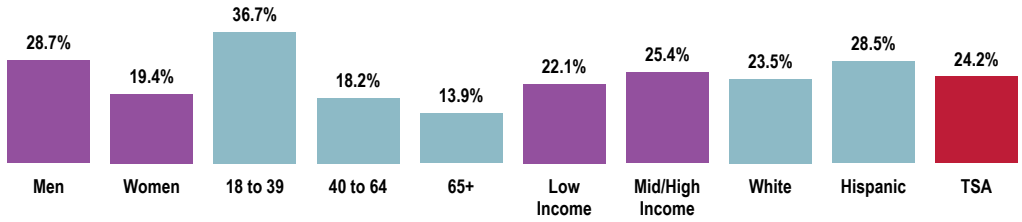
Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 126]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Meets Physical Activity Recommendations
(Total Service Area, 2022)
Healthy People 2030 = 28.4% or Higher



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 126]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

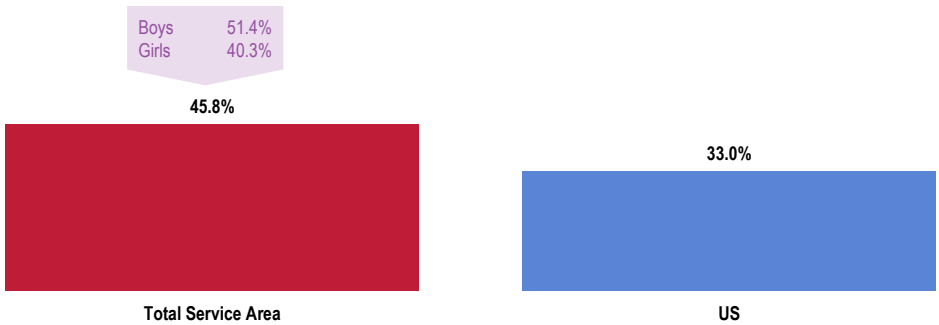
Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among Total Service Area children age 2 to 17, 45.8% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

BENCHMARK ► Better (higher) than the national finding.

Child Is Physically Active for One or More Hours per Day
(Parents of Children Age 2-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

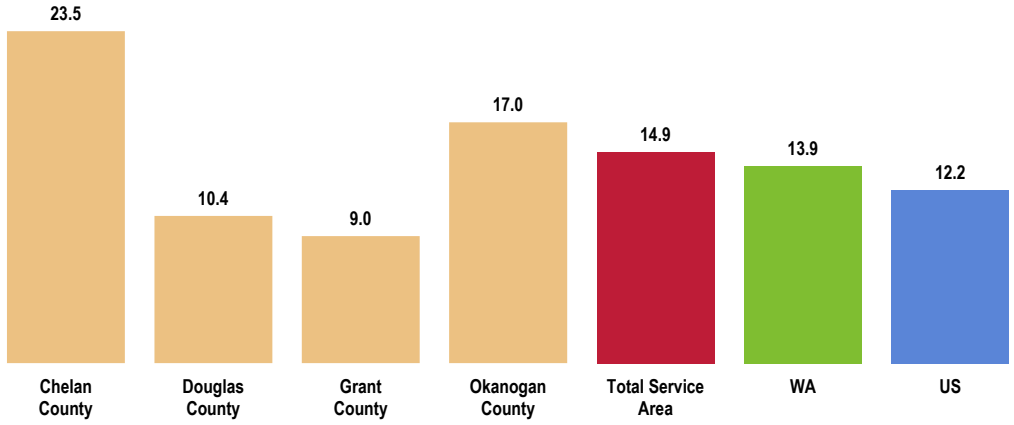
In 2019, there were 14.9 recreation/fitness facilities for every 100,000 population in the Total Service Area.

BENCHMARK ► Higher than the national rate.

DISPARITY ► Significantly fewer facilities in Douglas and Grant counties.

Population With Recreation & Fitness Facility Access

(Number of Recreation & Fitness Facilities per 100,000 Population, 2019)



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Overweight Status

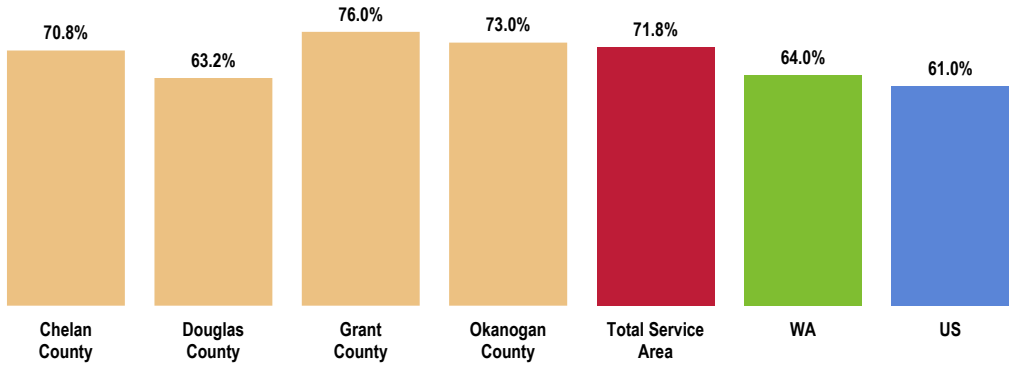
Here, "overweight" includes those respondents with a BMI value ≥25.

Just over 7 in 10 Total Service Area adults (71.8%) are overweight.

BENCHMARK ► Higher than the Washington and US percentages.

DISPARITY ► Unfavorably high in Grant County.

Prevalence of Total Overweight (Overweight and Obese)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

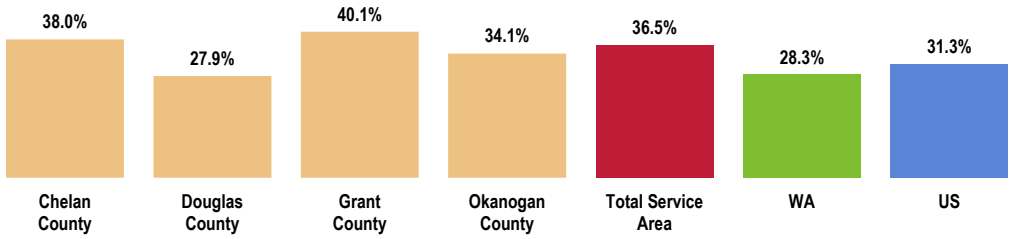
The overweight prevalence above includes 36.5% of Total Service Area adults who are obese.

BENCHMARK ► Higher than the Washington and US percentages.

DISPARITY ► Favorably low in Douglas County. Significantly higher among residents between the ages of 40 and 64.

Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower



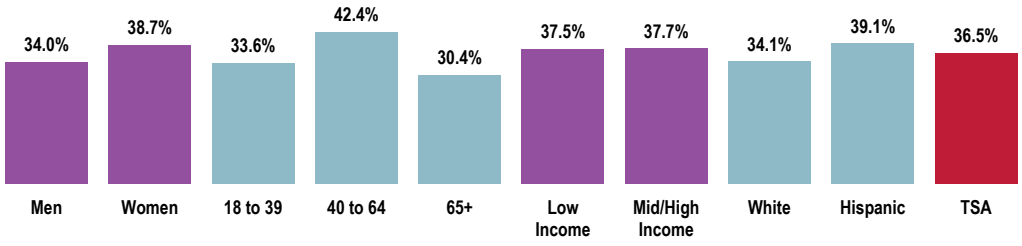
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity

(Total Service Area, 2022)

Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

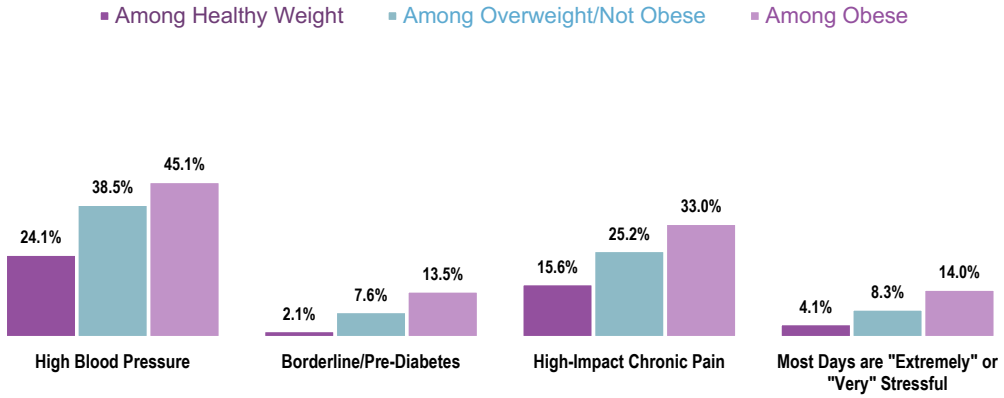
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions, as outlined in the following chart.

The correlation between overweight and various health issues cannot be disputed.

Relationship of Overweight With Other Health Issues
(Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
Notes: • Based on reported heights and weights, asked of all respondents.

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

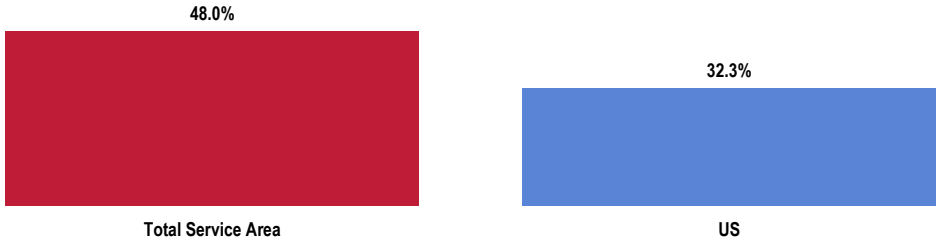
– Centers for Disease Control and Prevention

Children's Weight Status

Based on the heights/weights reported by surveyed parents, 48.0% of Total Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

BENCHMARK ► Higher than the national finding.

Prevalence of Overweight in Children
(Parents of Children Age 5-17)



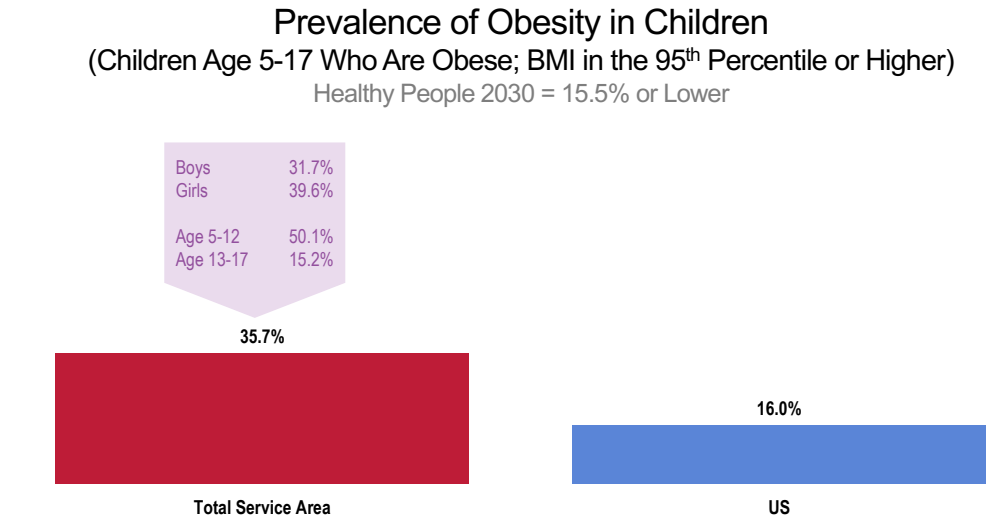
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

The childhood overweight prevalence above includes 35.7% of area children age 5 to 17 who are obese (≥95th percentile).

BENCHMARK ► Much higher than the national finding. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Reported among **half** of parents with children between the ages of 5 and 12.



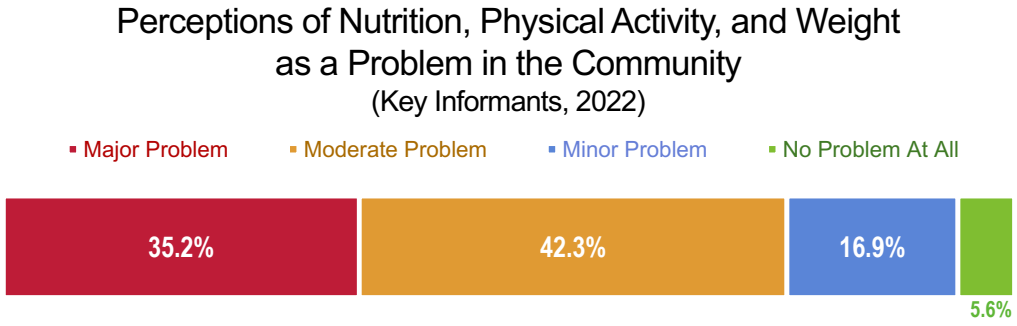
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Key Informant Input:

Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a "moderate problem" in the community.



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Resources and education to learn about proper nutrition and activity to reduce weight and chances of chronic disease. – Public Health Representative
>
> The false information about what our bodies need to be properly fueled and the culture of inactivity that pervades our society. I don't perceive doctors as being well-versed on diet either. Honestly, I don't trust the medical profession often when it comes to nutrition and physical activity. Doctors always want me to take a pill to treat the symptom, but hardly ever address the cause. – Community Leader
>
> Not understanding portion control. Eating healthy does not mean only eating salads. Ten minutes of activity makes a difference, just start. – Social Services Provider
>
> Where do our families go for education and exercise? – Community Leader

Contributing Factors

> Lack of information. Severe poverty. – Social Services Provider
>
> Cost of fresh fruits and vegetables and protein; even with access people don't teach them because they never learned to like them growing up. Screen time is excessive, too accessible, often used as a babysitter, so kids and adults are sedentary. Parents don't feel kids are safe playing outdoors in lots of neighborhoods or in remote locations. Overweight is seen as healthy–kids that have normal BMIs are thought of as too skinny. Organized sports are exclusive. Non-athletic kids lack safe exercise options. – Social Services Provider
>
> Lack of free public resources, bike paths, sidewalks, and healthy eating choices, combined with a short-sighted city government that doesn't support a positive, healthy lifestyle. – Community Leader
>
> POVERTY restricts budgets into filling food but not nutritionally adequate food. Local food pantry system does not receive enough food and support of volunteers to increase education around nutrition. More Incentives for physical activity are needed throughout the county and not just in the Omak Okanogan area. – Social Services Provider

Access to Care/Services

> There are not enough trauma informed body movement options. – Community Leader
>
> Time and availability of exercise opportunities (i.e., gyms, trails). – Community Leader
>
> Lack of recreational programs for all ages. – Community Leader
>
> Lack of activity spaces in downtown or other recreation areas, activity trails, adult "playgrounds," etc. Lots of fast-food restaurants, lack of healthy "fast food" options. – Community Leader

Access to Affordable Healthy Food

> Inability of low-income individuals to afford health foods, such as fresh fruits and vegetables. Prevalence of obesity that becomes generational. – Public Health Representative
>
> Many low-income folks don't seem to have resources to purchase health food. It appears that more means of intervention for all kinds of folks is necessary. – Community Leader
>
> Eating healthy is expensive. Subsidies should be available for healthy food. Community events and education should be available for people who want to make a change in lifestyle. Gyms can be expensive. – Community Leader

Lack of Providers

> Lack of nutritional counselors. – Public Health Representative

Lack of Time

> The time and ability to exercise and to make good food choices. – Social Services Provider

Obesity

> Increase in obesity rates. – Community Leader

SUBSTANCE ABUSE

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use – especially in adolescents – and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

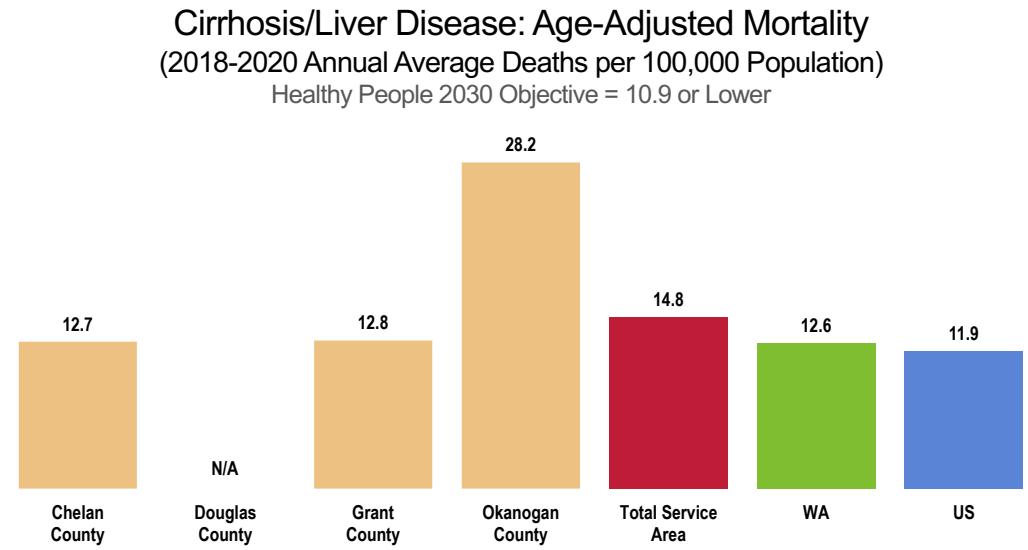
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2018 and 2020, the Total Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 14.8 deaths per 100,000 population.

BENCHMARK ► Worse than the US rate and fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Dramatically higher among Okanogan County residents.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Alcohol Use

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

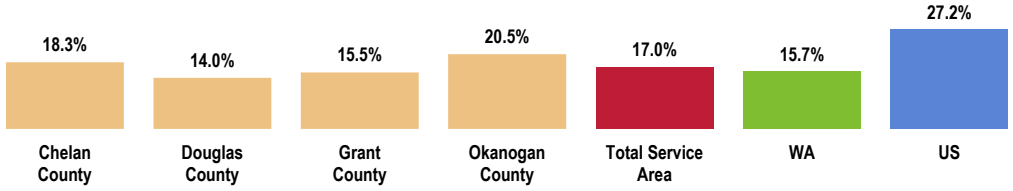
- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

A total of 17.0% of area adults are excessive drinkers (heavy and/or binge drinkers).

BENCHMARK ► Lower than the US percentage.

DISPARITY ► More often reported by men and residents under the age of 65.

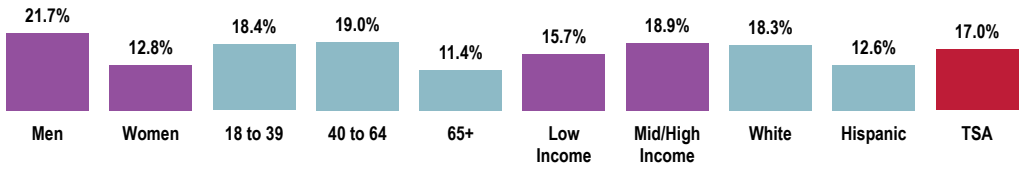
Excessive Drinkers



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 136]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Excessive Drinkers
(Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 136]
Notes: • Asked of all respondents.
• Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

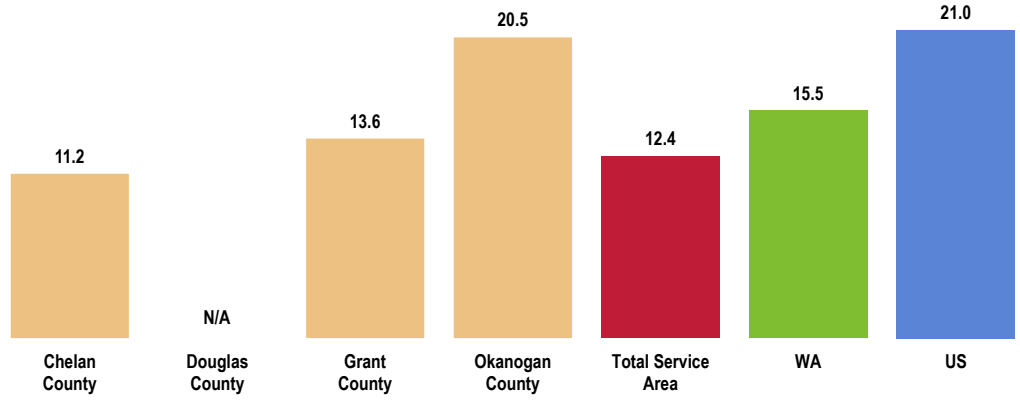
Age-Adjusted Unintentional Drug-Related Deaths

Between 2018 and 2020, there was an annual average age-adjusted unintentional drug-related mortality rate of 12.4 deaths per 100,000 population in the Total Service Area.

BENCHMARK ► Lower than the state and (especially) US mortality rates.

DISPARITY ► Highest in Okanogan County.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Illicit Drug Use

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

A total of 1.6% of Total Service Area adults acknowledge using an illicit drug in the past month.

BENCHMARK ► Satisfies the Healthy People 2030 objective.

DISPARITY ► Lowest in Douglas County.

Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower

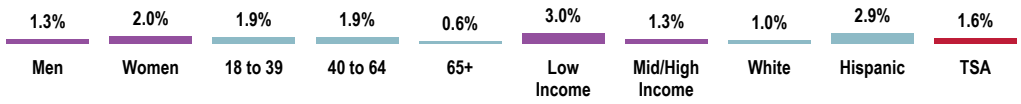
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 49]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Illicit Drug Use in the Past Month

(Total Service Area, 2022)

Healthy People 2030 = 12.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 49]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Use of Prescription Opioids

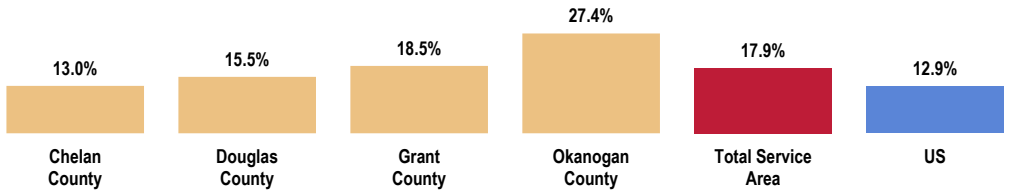
Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

A total of 17.9% of Total Service Area report using a prescription opioid drug in the past year.

BENCHMARK ► Higher than the national percentage.

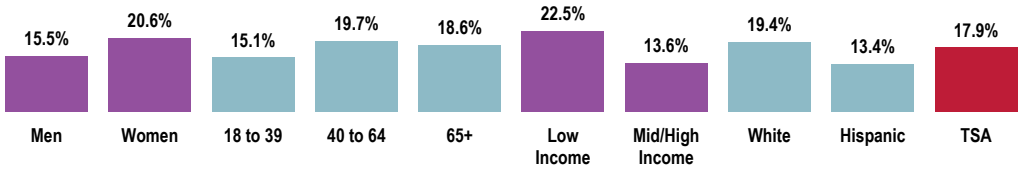
DISPARITY ► Significantly higher in Okanogan County. More often reported among low-income residents.

Used a Prescription Opioid in the Past Year



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 50]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Used a Prescription Opioid in the Past Year
(Total Service Area, 2022)



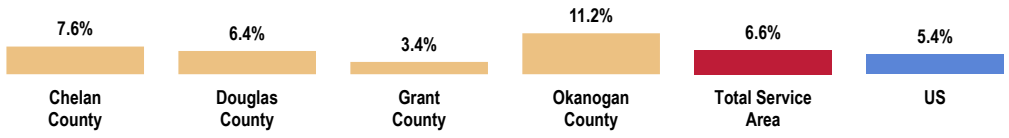
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 50]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Alcohol & Drug Treatment

A total of 6.6% of Total Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

DISPARITY ► Favorably high in Okanogan County.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem



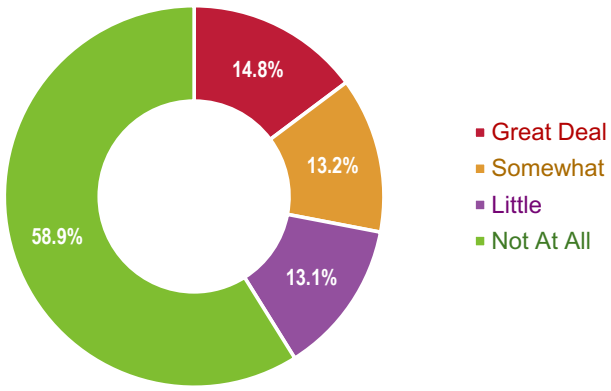
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 51]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Personal Impact From Substance Abuse

Area adults were also asked to what degree their lives have been impacted by substance abuse (whether their own abuse or that of another).

Most Total Service Area residents' lives have <u>not</u> been negatively affected by substance abuse (either their own or someone else's).

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)
(Total Service Area, 2022)



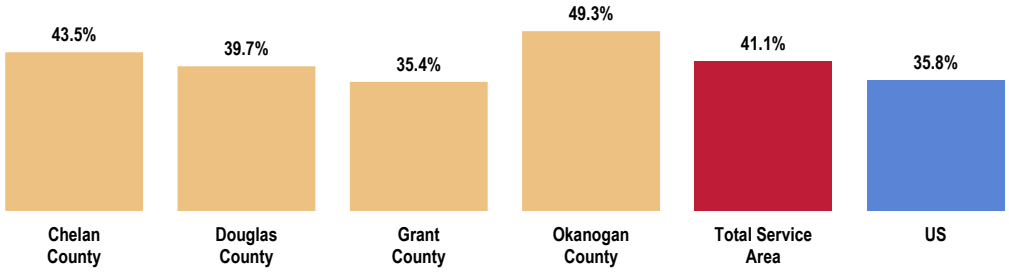
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: ● Asked of all respondents.

However, 41.1% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

BENCHMARK ► Higher than the national finding.

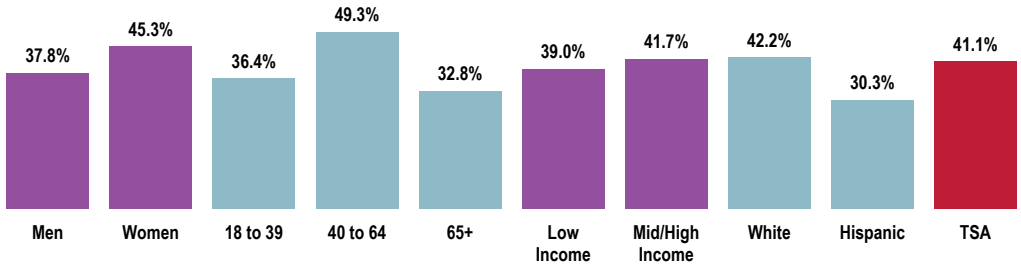
DISPARITY ► Unfavorably high in Okanogan County. More often reported among women, adults aged 40 and 64, and non-Hispanic White residents.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes response of "a great deal," "somewhat," and "a little."

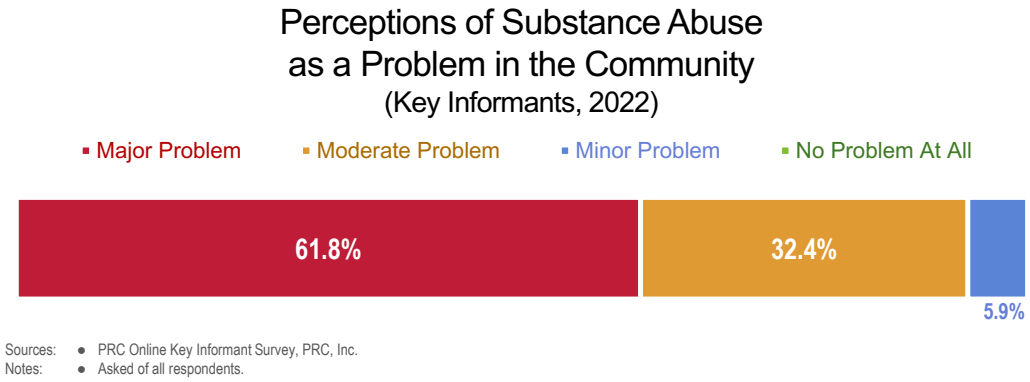
Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
(Total Service Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: ● Asked of all respondents.
● Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

The greatest share of key informants taking part in an online survey characterized *Substance Abuse* as a "major problem" in the community.



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Again, no inpatient services. – Community Leader
>
> I am unaware of any substance abuse treatment in my community. – Community Leader
>
> Intake process is slow and cumbersome. Supporters of a family member with substance abuse do not know of the services available. Too difficult to access help. – Community Leader
>
> Few slots are available for treatment and many that need it, most have impaired judgement and will not seek it. There needs to be a better mechanism to move people into treatment, even if they are resistant. – Community Leader
>
> We only have one center that I know of that works to address substance abuse treatment and recovery. There is a long wait list and not enough room to detox in the facility. – Social Services Provider
>
> Immediate availability. – Community Leader
>
> Access to mental health. – Social Services Provider
>
> Lack of treatment services in Grant County. – Public Health Representative
>
> Lack of quality treatment facilities. Lack of inpatient treatment centers. Lack of housing so people abusing substances can have a stable environment to begin treatment and stay clean and sober. – Public Health Representative
>
> THC-based vape use is on the rise in our school age children. – Community Leader
>
> There are not enough facilities for detox or treatment. – Community Leader

Contributing Factors

> Recent changes to State law regarding possession and use of drugs have made it impossible to mandate treatment (e.g. – Drug Court for non-violent felony convictions). There is very little proactive efforts being made in our community. Our treatment centers have little to no outreach effort and general rely on referrals from other agencies. Treatment workers rarely leave the facilities where they work, rather than going to the person suffering from addiction (jails, homes, homeless encampments, etc.). – Community Leader
>
> I think this goes hand-in-hand with mental health. Not having enough access to resources, shelter, food, support. – Community Leader
>
> Social stigmas, losing work/income, lack of insurance/no way to pay for treatment, lack of enforcement by law officials to follow-through with treatment. – Community Leader

> We do not have sufficient counselors and providers, places to serve people. Substance use disorder has intergenerational impact, hard to stop the cycle. There is drug trafficking, users, dealers, diversion, an alternative source of income. – Social Services Provider
>
> Getting people into treatment centers in a timely manner. Limited pathways to get out of addiction and become a contributing member of society (limited job opportunities, safe places to live, sustainable mental health care). – Social Services Provider

Lack of Providers

> Lack of providers, both inpatient and outpatient, transportation, and transitional housing to accompany treatment and after care. – Social Services Provider
>
> Need more providers and an option for longer term stays, then more transitional housing when they leave inpatient programs. – Community Leader
>
> Not enough providers. – Other Health Provider
>
> Lack of providers and appropriate medical coverage. – Other Health Provider

Denial/Stigma

> Community stigma. – Public Health Representative
>
> Many people are afraid to "deal" with people who have substance abuse issues. The population doesn't want to admit that we have problems such as these. – Social Services Provider
>
> Stigma is a significant barrier. – Community Leader

Easy Access

> Student access and increased usage has been noted in the school. Often difficult to get assistance from county entities. – Community Leader
>
> Access and availability for youth. – Community Leader

Homelessness

> Intervention is necessary "on the street." – Community Leader
>
> Increase in homeless population and correlation to drug use. – Community Leader

Incidence/Prevalence

> Substance use disorder. – Community Leader
>
> We have seen a substantial increase in substance abuse over the past two years and there doesn't seem to be much in the way of support. – Community Leader

Lack of Coordination of Services

> Coordination of services and a need to create stronger partnerships. – Social Services Provider

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **alcohol** as causing the most problems in the community, followed by **heroin/other opioids, methamphetamine/other amphetamines, prescription medications, marijuana, and club drugs**.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a "Major Problem")	
ALCOHOL	48.5%
HEROIN OR OTHER OPIOIDS	24.2%
METHAMPHETAMINE OR OTHER AMPHETAMINES	18.2%
PRESCRIPTION MEDICATIONS	3.0%
MARIJUANA	3.0%
CLUB DRUGS (e.g. MDMA, GHB, Ecstasy, Molly)	3.0%

TOBACCO USE

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

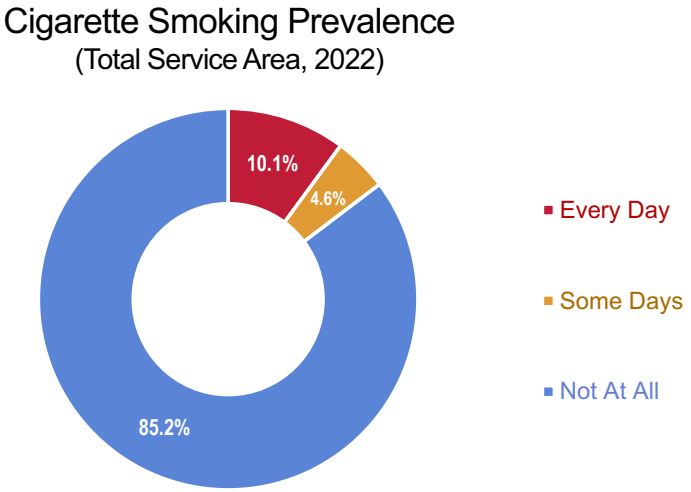
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 14.7% of Total Service Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: • Asked of all respondents.

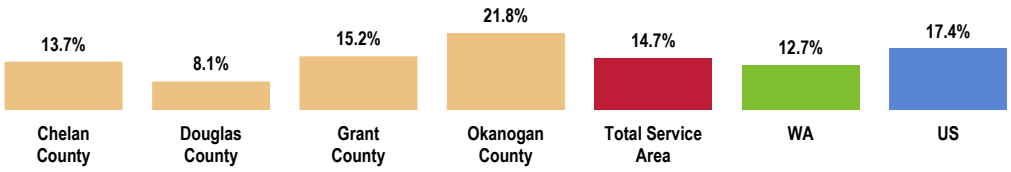
Note the following findings related to cigarette smoking prevalence in the Total Service Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Unfavorably high in Okanogan County. Cigarette smoking is higher among adults aged 40 to 64, lower-income residents, and non-Hispanic White residents.

Current Smokers

Healthy People 2030 = 5.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers

(Total Service Area, 2022)

Healthy People 2030 = 5.0% or Lower

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

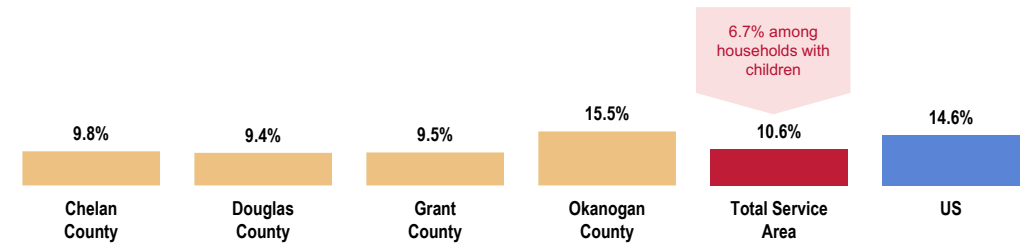
Notes:
- Asked of all respondents.
- Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

Among all surveyed households in the Total Service Area, 10.6% report that someone has smoked cigarettes in their home on an average of four or more times per week over the past month.

BENCHMARK ► Lower than the US finding.

Member of Household Smokes at Home



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

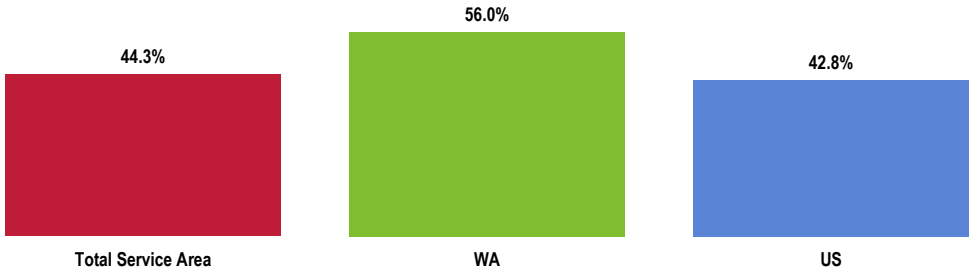
Smoking Cessation

44.3% of regular smokers went without smoking for one day or longer in the past year because they were trying to quit smoking.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

Have Stopped Smoking for One Day or Longer in the Past Year
(Everyday Smokers)
Healthy People 2030 = 65.7% or Higher

Most current smokers (62.6%) were advised to quit in the past year by a health care professional.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 41-42]
- 2020 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

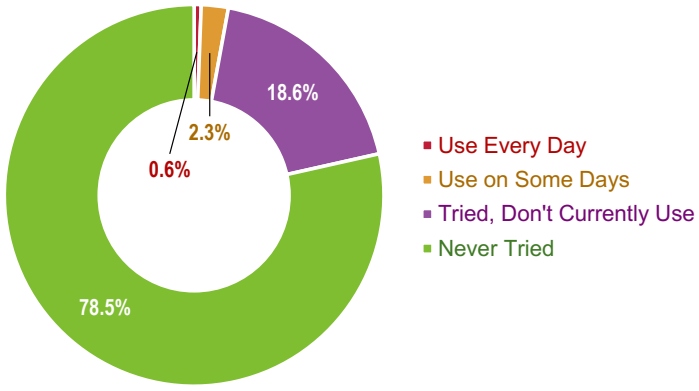
Notes:
- Asked of respondents who smoke cigarettes every day.

Other Tobacco Use

Use of Vaping Products

Most Total Service Area adults have never tried electronic cigarettes (e-cigarettes) or other electronic vaping products.

Use of Vaping Products
(Total Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 135]

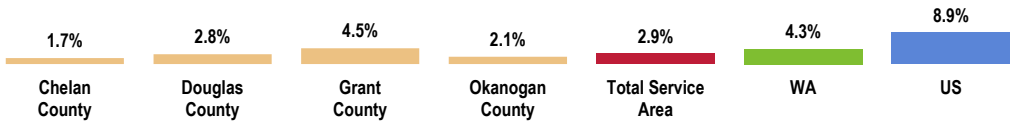
Notes:
- Asked of all respondents.

However, 2.9% currently use vaping products either regularly (every day) or occasionally (on some days).

BENCHMARK ► Lower than the Washington and (especially) US percentages.

DISPARITY ► Higher use of vaping products reported among those under the age of 65 and low-income residents.

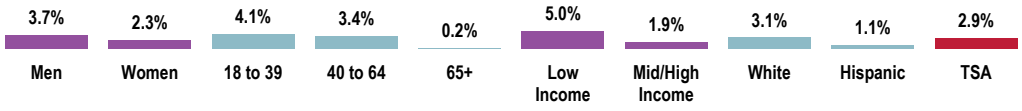
Currently Use Vaping Products
(Every Day or on Some Days)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 135]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Currently Use Vaping Products
(Total Service Area, 2022)

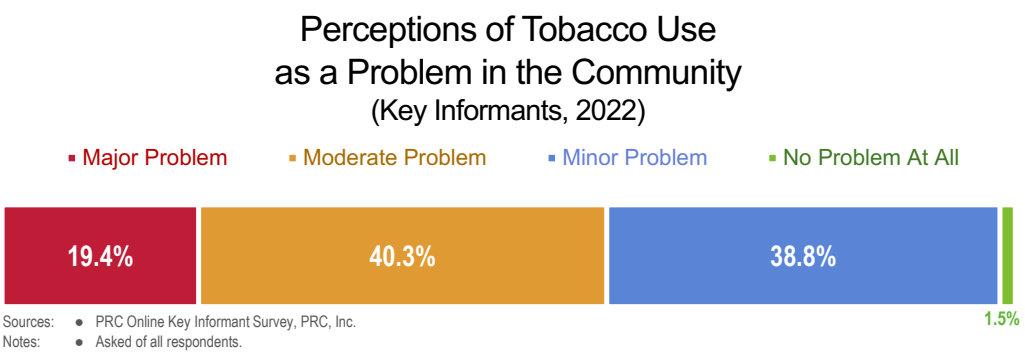


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 135]

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The greatest share of key informants taking part in an online survey characterized *Tobacco Use* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Purely anecdotally, this community appears to have a high number of active tobacco users. – Community Leader
>
> I see so many people smoking or using chewing tobacco in the community. – Social Services Provider
>
> I feel that tobacco use, including e-cigarettes, are huge issues for teenagers under 18. – Community Leader
>
> Vaping. Student access and usage of vaping in schools has increased dramatically. – Community Leader
>
> Young people are vaping at incredibly high numbers, mirroring other issues that arose during the pandemic. – Social Services Provider

Easy Access

> It just happens to be easily accessible to our youth. – Social Services Provider

Contributing Factors

> The region has a high incidence of COPD, lung cancer, and heart disease, all connected to smoking. Lower socioeconomic populations tend to smoke more than wealthier communities. – Public Health Representative

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year – and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

HIV Prevalence

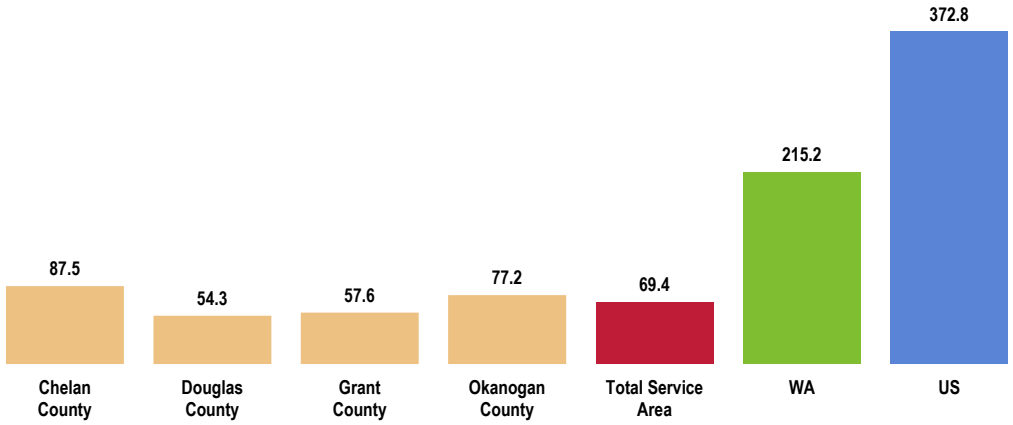
In 2018, there was a prevalence of 69.4 HIV cases per 100,000 population in the Total Service Area.

BENCHMARK ► Well below the state and national findings.

DISPARITY ► Highest among residents of Chelan County.

HIV Prevalence

(Prevalence Rate of HIV per 100,000 Population, 2018)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Sexually Transmitted Infections (STIs)

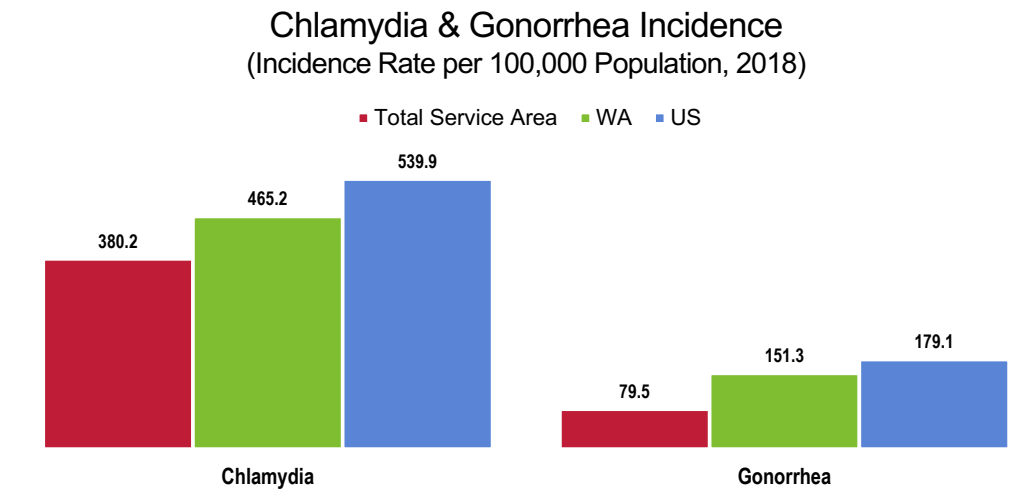
Chlamydia & Gonorrhea

In 2018, the chlamydia incidence rate in the Total Service Area was 380.2 cases per 100,000 population.

The Total Service Area gonorrhea incidence rate in 2018 was 79.5 cases per 100,000 population.

BENCHMARK ► Both chlamydia and gonorrhea incidence rates were lower than the related state and national rates.

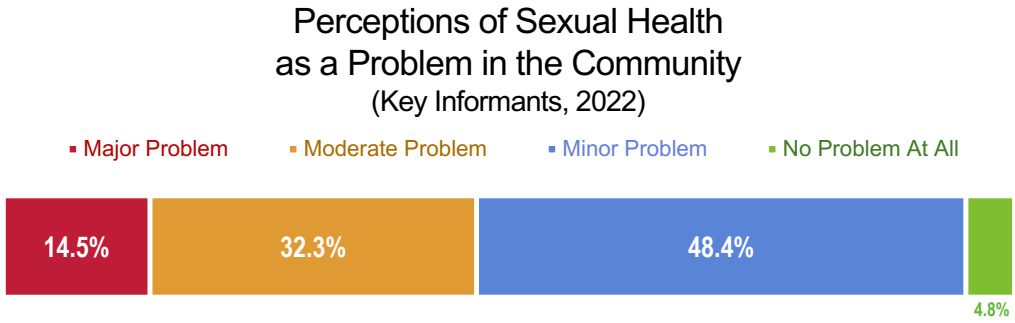
DISPARITY ► Gonorrhea incidence is unfavorably high in Grant County (not shown).



Sources: ● Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
Notes: ● This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

A plurality of key informants taking part in an online survey characterized *Sexual Health* as a "minor problem" in the community.



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Inadequate access to prophylactics and open communication with students about sexual health. – Public Health Representative
>
> No medically accurate comprehensive sexual health being taught in schools. Abstinence is only models being pushed forward even though they are proven not to work. Youth being sexually exploited and/or abused from a very young age. – Social Services Provider
>
> I do not believe high school students are taught healthy/safe ways of maturing sexually. Access to women's health clinics for young adults is limited. Region has reputation in the past of lots of STDs and teen pregnancies. – Community Leader

Awareness/Education

> Lack of reproductive health education. – Public Health Representative

Access to Care/Services

> In the greater north central Washington tri-county area, there are huge expanses of area that have no sexual health resources. That means individuals have to independently find transportation, take time out of their schedules, and seek out these health resources, which are already shrouded in shame. – Community Leader

Teen Pregnancy

> Teen pregnancies. – Community Leader

ACCESS TO HEALTH CARE

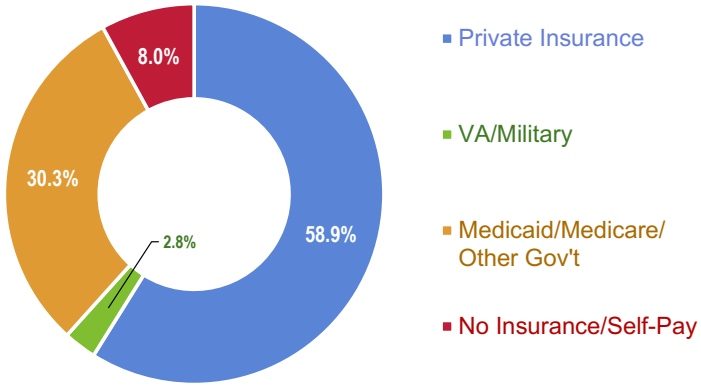
HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 58.9% of Total Service Area adults age 18 to 64 report having health care coverage through private insurance. Another 33.1% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Health Care Insurance Coverage
(Adults Age 18-64; Total Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
Notes: • Reflects respondents age 18 to 64.

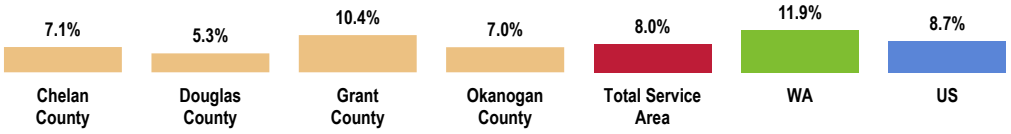
Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 8.0% report having no insurance coverage for health care expenses.

BENCHMARK ► Better (lower) than the Washington finding.

Lack of Health Care Insurance Coverage
(Adults Age 18-64)
Healthy People 2030 = 7.9% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage
(Adults Age 18-64; Total Service Area, 2022)
Healthy People 2030 = 7.9% or Lower

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication – in person or remotely – can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Difficulties Accessing Services

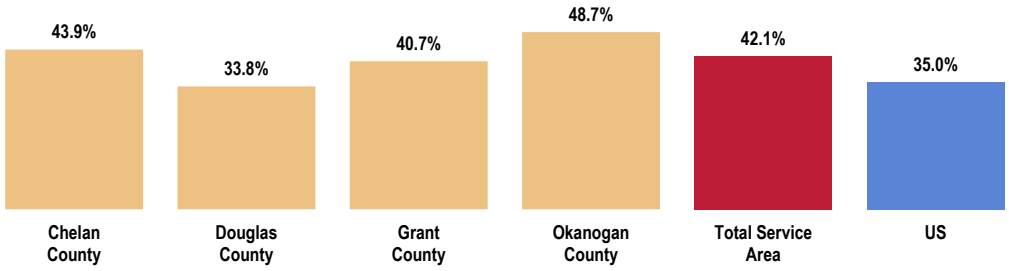
This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

A total of 42.1% of Total Service Area adults report some type of difficulty or delay in obtaining health care services in the past year.

BENCHMARK ► Higher than the US percentage.

DISPARITY ► More often reported among those between the ages of 40 and 64 and non-Hispanic White residents.

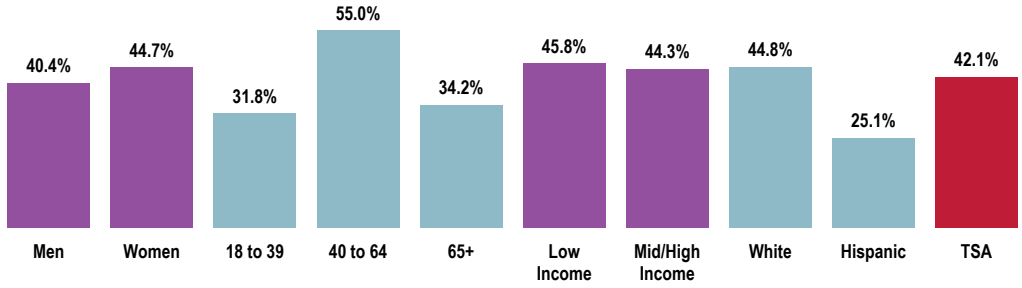
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Total Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 140]

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Barriers to Health Care Access

Of the tested barriers, appointment availability and difficulty finding a physician impacted the greatest shares of Total Service Area adults.

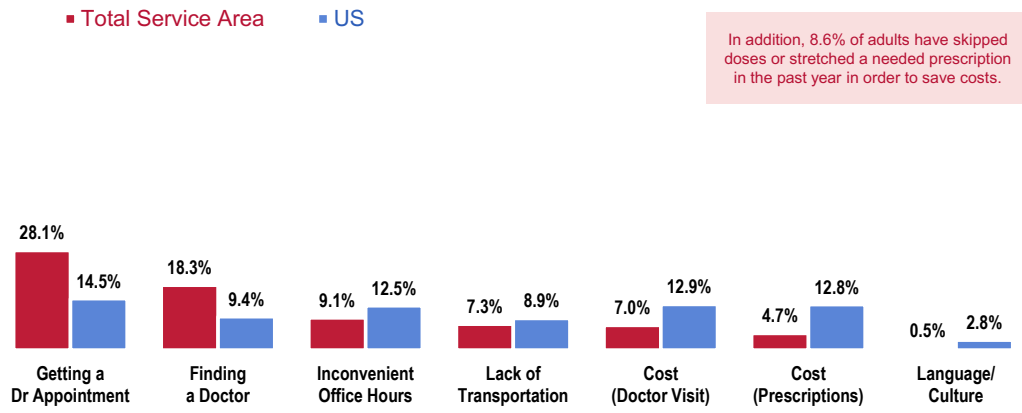
BENCHMARK ► The barriers of appointment availability and difficulty finding a physician affect service area adults significantly more than they do adults across the US. Conversely, cost (of doctors visit/ prescriptions), inconvenient office hours, and language/cultural barriers affect service area adults significantly less than they do adults across the US.

DISPARITY ► Appointment availability issues, difficulty finding a physician, and transportation problems were even higher in Okanogan County (not shown).

To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year



In addition, 8.6% of adults have skipped doses or stretched a needed prescription in the past year in order to save costs.

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 7-13]
- 2020 PRC National Health Survey, PRC, Inc.

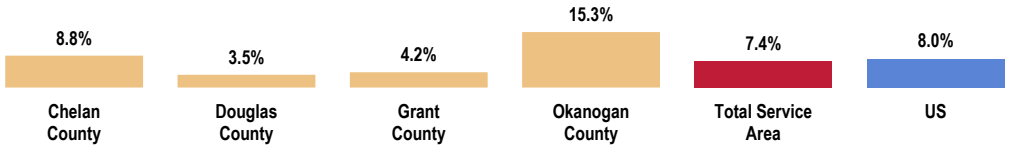
Notes:
- Asked of all respondents.

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

A total of 7.4% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)

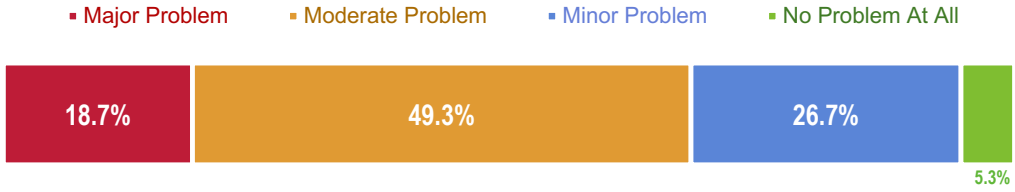


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 104]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

Key informants taking part in an online survey most often characterized *Access to Health Care Services* as a "moderate problem" in the community.

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> In Chelan, Douglas and Okanogan counties Wenatchee offers the most condensed and extensive healthcare services. These three counties make up a huge geographical area, meaning that folks who do not live in the immediate Wenatchee area have to find suitable and timely transportation to even GET to health care. There are not enough providers for the demand. Options are either emergency department or waiting months for an appointment, and that doesn't include specialized care. – Community Leader

> It takes a very long time to get an appointment in almost all specialties. Patients should be able to schedule appointments online (this was an option at one time). Playing email tag back and forth through the MyChart request an appointment functionality is more inefficient than just making a phone call. – Community Leader
>
> Very limited access to general healthcare during last two years, long wait for appointments, long wait for specialty care. – Public Health Representative
>
> DISTANCE DISTANCE DISTANCE. I currently have two neighbors who are in major pain with sciatica to the point that they can barely walk. One was instructed to come to Wenatchee to be seen. After that he was instructed to come to Wenatchee again to have an MRI. A third appointment revealed that the MRI was defective, so he had to go home and come back down again and then was referred to a pain clinic in Omak. This is a gentleman in his late 70s. He had to have an 80-year-old neighbor drive him down. My other neighbor is younger but undergoing the same expectation to drive down to Wenatchee. Driving, let alone riding in a car is the worst thing you can do for sciatica but there is no consideration of the difficulty. For example, when the MRI was defective in the first case – why didn't a new MRI get processed that day? and maybe even have an appointment for review to save him from the pain let alone the expense of travel for a senior citizen. There has to be expansion of services. – Social Services Provider
>
> Accessibility to alternative therapeutic services and occupational, physical, and speech language pathology for children with disabilities. – Social Services Provider
>
> North Central has insufficient educational outreach on preventive health actions for issues like diabetes, heart health, and other chronic illnesses. – Other Health Provider
>
> Ability to get appointments with doctors' offices. – Community Leader
>
> Primary Care. – Other Health Provider
>
> It takes weeks and sometimes months to get test results completed after the initial appointment is made. Reaching a specialist is time consuming through Confluence Health, it's much faster to leave Confluence and travel to another facility or community. – Community Leader
>
> Appointments are very difficult to get with healthcare providers. – Community Leader

Lack of Providers

> Recruiting, and retaining, quality physicians to our local clinics. It is difficult to establish care as well as a relationship with a physician when they move or are relocated shortly thereafter. – Community Leader
>
> It seems that few specialists are traveling to outlying areas, making the only access to specialized care in Wenatchee, Spokane or Seattle. This creates a problem for some in the areas to access health care services because of transportation. – Community Leader
>
> The biggest challenge is hiring and retaining qualified professionals to provide the service. – Social Services Provider
>
> This is not so much a health issue as a gap in regional services. Transgender services are very hard to come by in our valley and I'm not certain how welcoming our region is to people who are LGBTQ+. Would be great to have specialty services that could serve transgender people so they would not have to travel out of area to meet their health needs. – Other Health Provider
>
> Covid restrictions making it impossible to get any services at all. – Community Leader

Insurance Issues

> Lack of adequate insurance coverage creating reluctance to seek medical services. Lack of physicians, particularly specialists, creating long wait times to see medical providers. Lack of adequate skilled nursing facility beds resulting in a lack of placement options. Shortage of medical staff, including nurses, trained care providers, CNAs, specialists, and PCP doctors in that order. – Public Health Representative

Transportation

> Low-income households not having access to reliable transportation or phone/Wi-Fi. Public transportation is not reaching our most rural areas. Financial barriers. Fear around health services in the farmworker community. – Social Services Provider

Vision Care

> Vision, for the same reason. Not covered by Medicare. Medicare is now costing one senior $285 per month off the top of their already low SS income. Unaffordable and soon many more seniors will be homeless. This is a crisis. – Community Leader

> Access to eye care is a problem....6-8 months out for an appointment. Employee satisfaction is a problem and impacting the community perception of the CH organization. This results in people leaving the valley for their healthcare needs and truly is resulting in a healthcare issue. CH HR has a terrible reputation in the community. Support your healthcare teams, be willing to modify hours and shifts to retain loyal employees. Give your managers some training, some are woefully under prepared academically and experientially for the jobs they have been hired to. – Community Leader

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death – yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

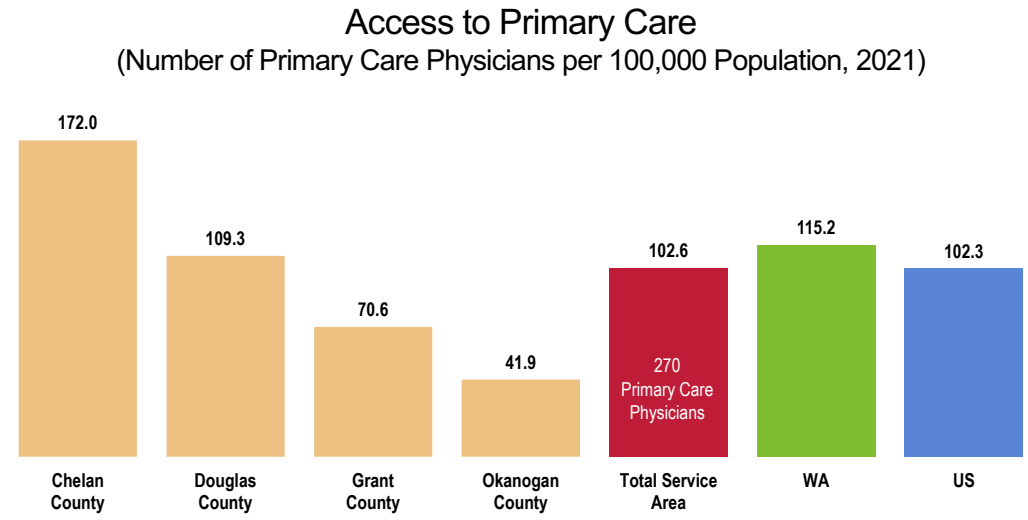
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

In 2021, there were 270 primary care physicians in the Total Service Area, translating to a rate of 102.6 primary care physicians per 100,000 population.

DISPARITY ► Significantly fewer in Grant and Okanogan Counties.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Specific Source of Ongoing Care

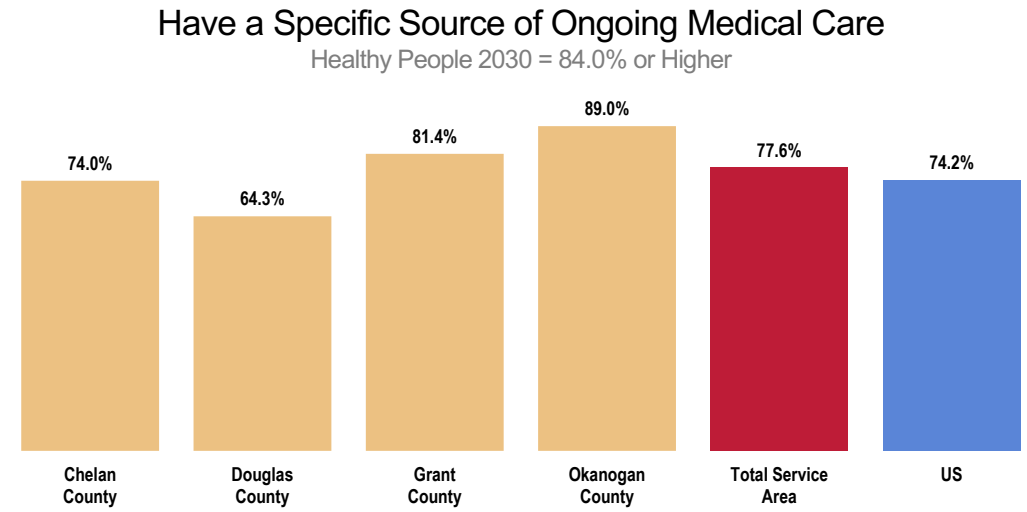
Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

A hospital emergency room is not considered a specific source of ongoing care in this instance.

A total of 77.6% of Total Service Area adults were determined to have a specific source of ongoing medical care.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Significantly lower in Douglas County.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 139]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Utilization of Primary Care Services

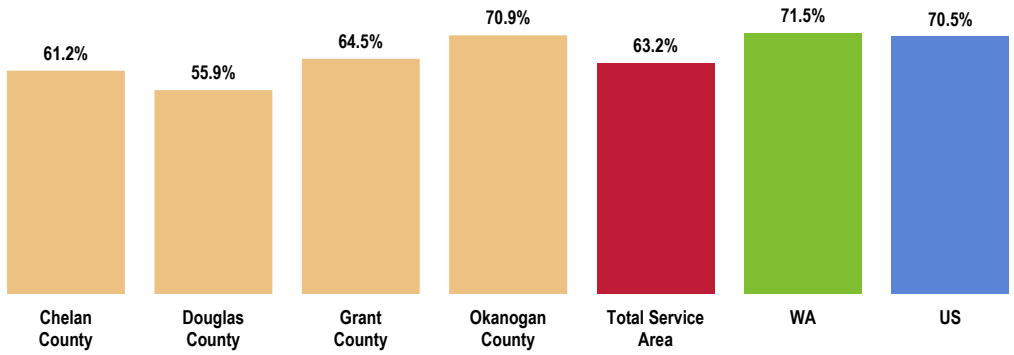
Adults

Over 6 in 10 adults (63.2%) visited a physician for a routine checkup in the past year.

BENCHMARK ► Lower than the Washington and national findings.

DISPARITY ► Favorably high in Okanogan County. Primary care utilization increases with age among service area adults.

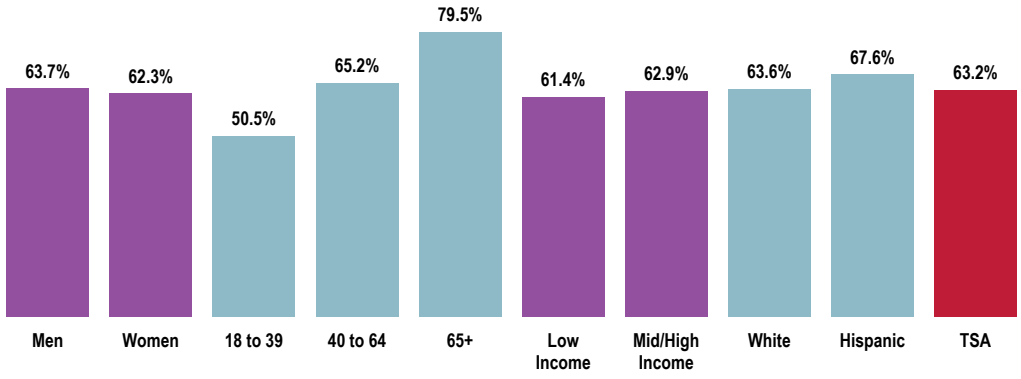
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year
(Total Service Area, 2022)



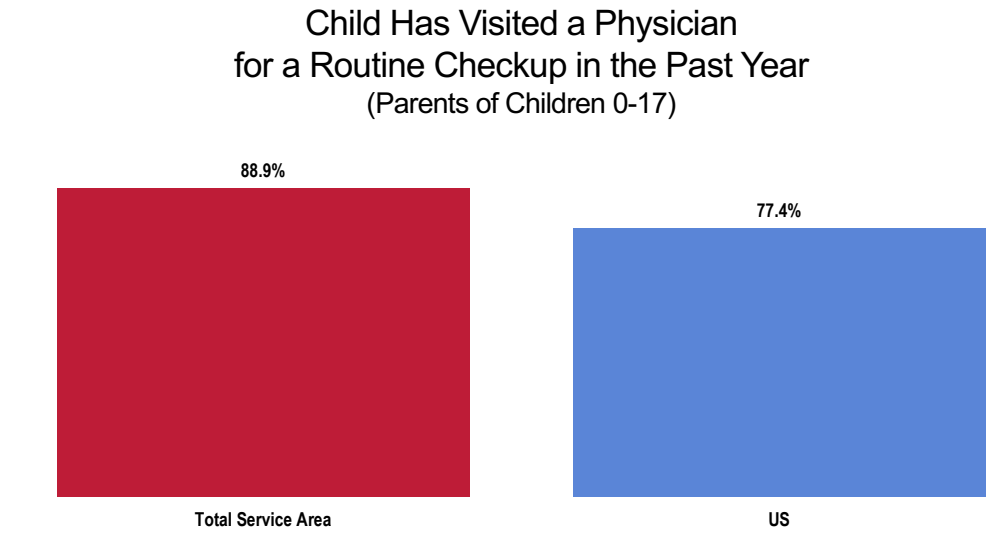
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 18]

Notes:
- Asked of all respondents.

Children

Among surveyed parents, 88.9% report that their child had a routine checkup in the past year.

BENCHMARK ► Higher than the US percentage.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2020 PRC National Health Survey, PRC, Inc.

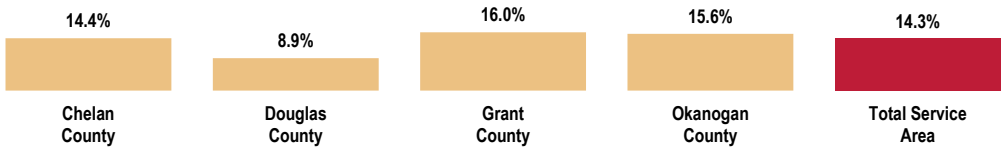
Notes:
- Asked of all respondents with children 0 to 17 in the household.

Avoided Care Due to COVID-19

Among service area adults, 14.3% report avoiding medical care in the past year due to concerns about the COVID-19 pandemic.

DISPARITY ► Lowest in Douglas County. Care was avoided more often by women and residents between the ages of 40 and 64.

Avoided Medical Care in the Past Year Due to Concerns About COVID-19



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: • Asked of all respondents.

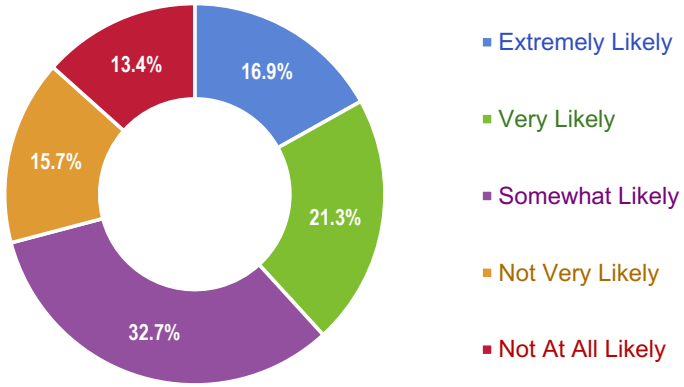
Avoided Medical Care in the Past Year Due to Concerns About COVID-19
(Total Service Area, 2022)

Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: • Asked of all respondents.

Telemedicine

The majority of respondents were at least "somewhat" likely to use telemedicine for routine care in the future.

Likelihood of Using Telemedicine for Routine Care in the Future
(Total Service Area, 2022)

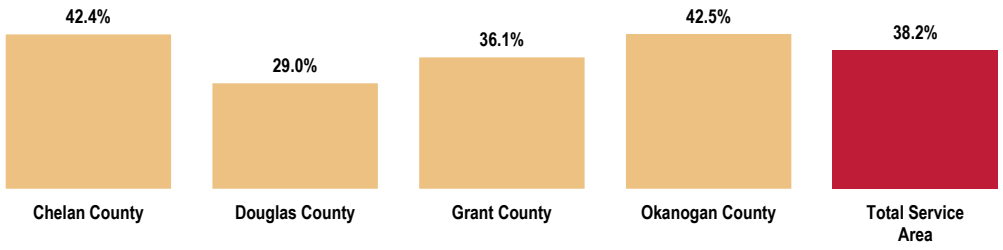


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: • Asked of all respondents.

In fact, among surveyed adults, 38.2% report being "extremely" or "very" likely to utilize telemedicine in the future.

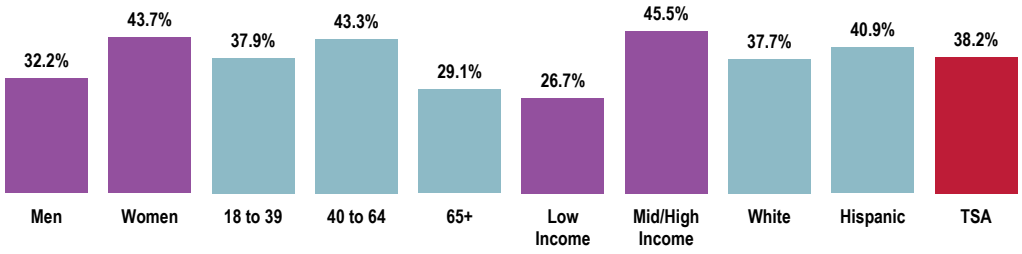
DISPARITY ► Lowest in Douglas County. Significantly lower among men, seniors, and low-income residents.

"Extremely" or "Very" Likely to Use Telemedicine for Routine Care



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: • Asked of all respondents.

"Extremely" or "Very" Likely to Use Telemedicine for Routine Care
(Total Service Area, 2022)



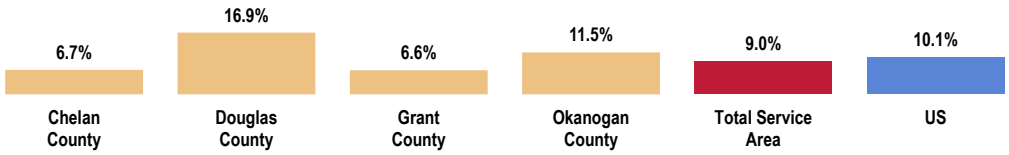
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: • Asked of all respondents.

EMERGENCY ROOM UTILIZATION

A total of 9.0% of Total Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

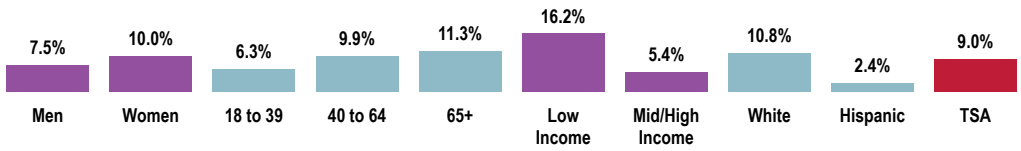
DISPARITY ► Significantly higher in Douglas County. More often reported by lower-income and non-Hispanic White residents.

Have Used a Hospital Emergency Room More Than Once in the Past Year



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 22]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year
(Total Service Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 22]
Notes: ● Asked of all respondents.

ORAL HEALTH

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

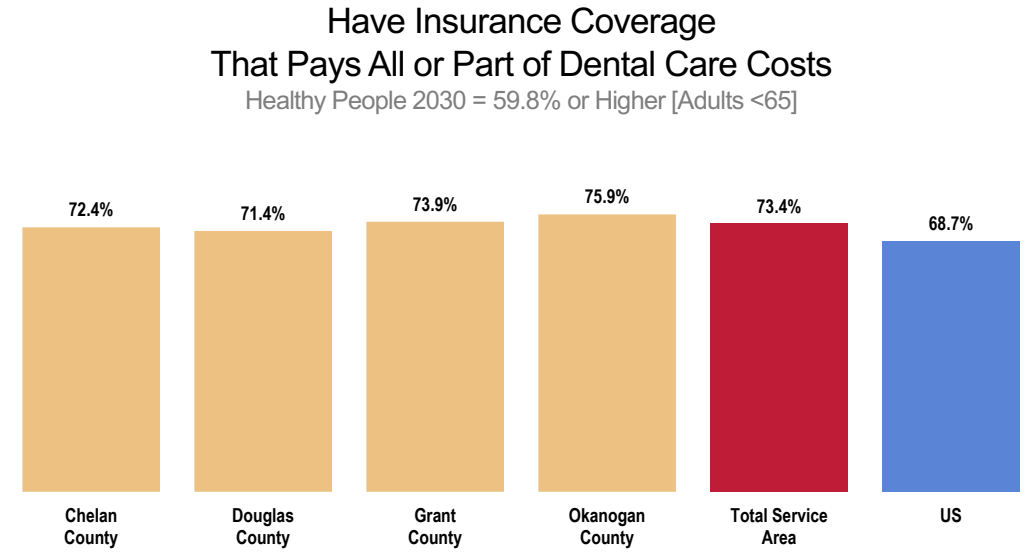
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Insurance

Nearly three in four Total Service Area adults (73.4%) have dental insurance that covers all or part of their dental care costs.

BENCHMARK ▶ Higher than the national percentage. Satisfies the Healthy People 2030 objective.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 21]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Dental Care

Adults

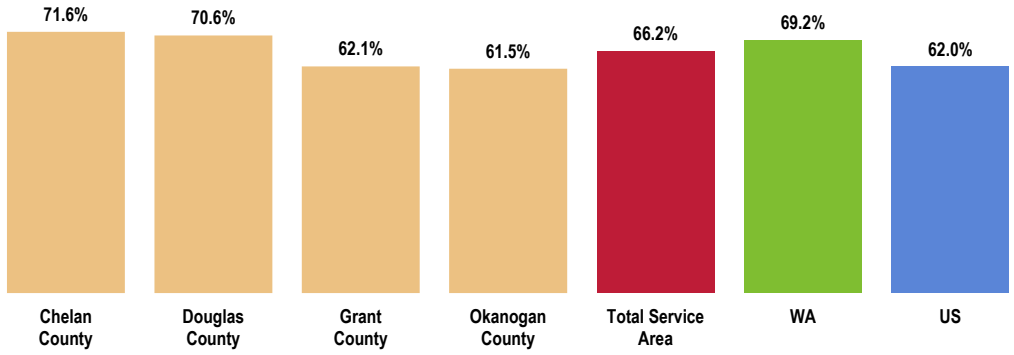
Two in three (66.2%) Total Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

BENCHMARK ▶ Satisfies the Healthy People 2030 objective.

DISPARITY ▶ Favorably high in Chelan County. Those less likely to receive dental care include low-income residents.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



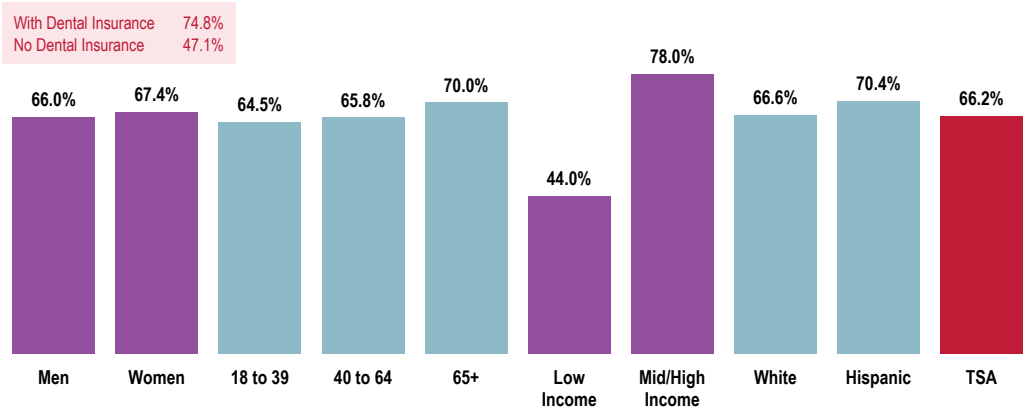
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Washington data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

(Total Service Area, 2022)

Healthy People 2030 = 45.0% or Higher



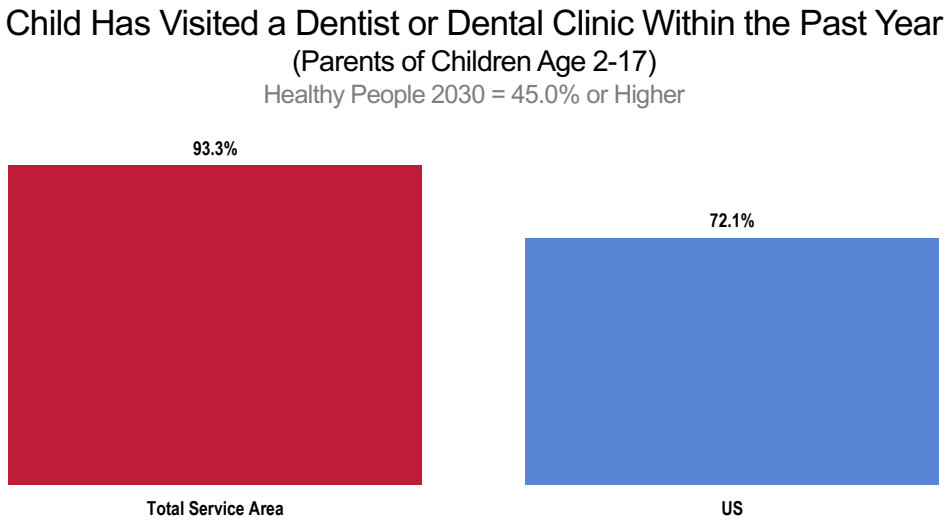
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 20]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Children

A total of 93.3% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

BENCHMARK ► Higher than the national finding. Satisfies the Healthy People 2030 objective.

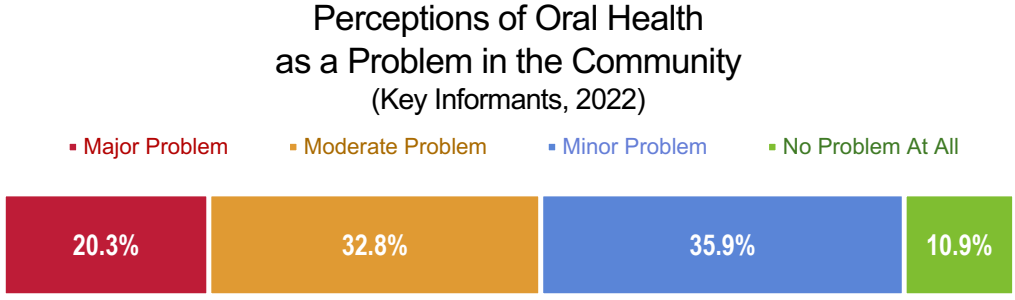


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 108]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "minor problem" in the community.



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> There are not enough dentists, hygienists and there are very few who have dental insurance coverage. Too expensive. Water is not fluoridated. People don't have good brushing habits. Diets are poor and increase tooth decay. – Social Services Provider
>
> There is a lack of dentists in the community. – Social Services Provider
>
> Because Medicare does not cover oral health, supplement plans are unaffordable for many seniors living on SS income only. If they even have a home these days. – Community Leader
>
> I think oral health is a major problem because smoking tobacco and other drug use is a big problem. Also, lack of pediatric dentist options in the region. I think the only one is in Moses Lake with two doctors. – Community Leader

Access for Medicare/Medicaid Patients

> Lack of dentists in the private sector that take Medicaid/Medicare. – Public Health Representative
>
> Lack of care for Medicaid clients. – Other Health Provider
>
> Medicare and Medicaid do not cover dental care. Most Medicare Advantage Programs do not have dental coverage. The free or low-cost dental clinics will pull teeth, but they will not treat cavities, do crowns, or even preventive dental services. – Public Health Representative

Access to Care for Uninsured/Underinsured

> Dentistry is not accessible, many people do not have dental insurance, prices can quickly become astronomical. FHC's Dental Clinic is usually booked out for close to a year. Many local dental offices are not taking new clients. – Social Services Provider
>
> Lack of access for indigent population who need more preventative care, underinsured, or not insured. – Social Services Provider

Affordable Care/Services

> It's too expensive unless you have insurance, but the insurance isn't that great either. – Community Leader
>
> I feel like dental insurance is harder to come by and dental care is more expensive for more people. – Community Leader

VISION CARE

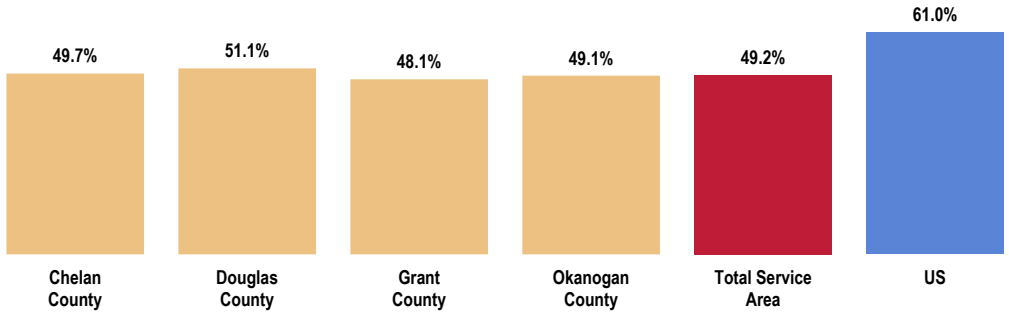
A total of 49.2% of Total Service Area residents had an eye exam in the past two years during which their pupils were dilated.

BENCHMARK ► Lower than the US percentage. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Eye exam rates are lower among men and young adults.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

Healthy People 2030 = 61.1% or Higher



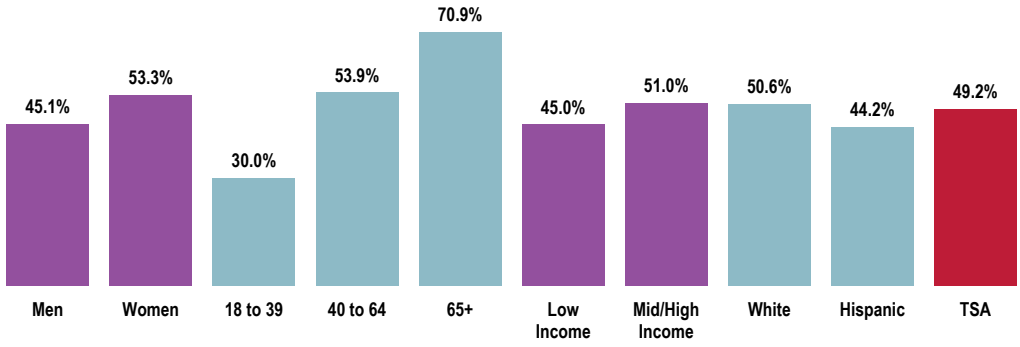
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 19]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(Total Service Area, 2022)

Healthy People 2030 = 61.1% or Higher



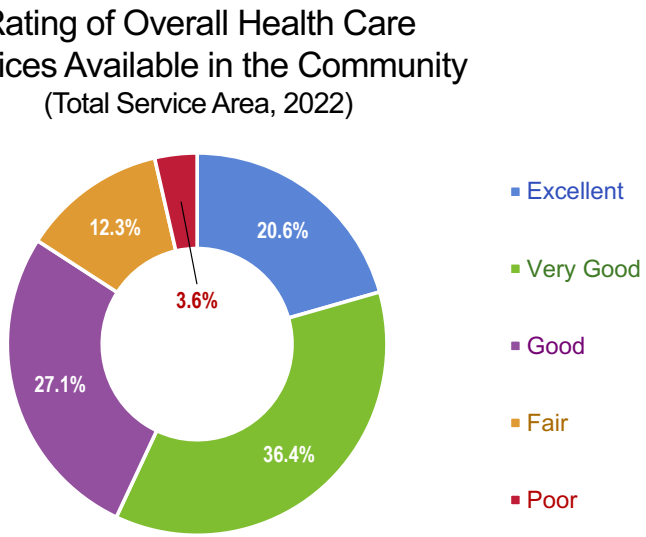
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 19]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

LOCAL RESOURCES

PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

Most Total Service Area adults rate the overall health care services available in their community as "excellent" or "very good."

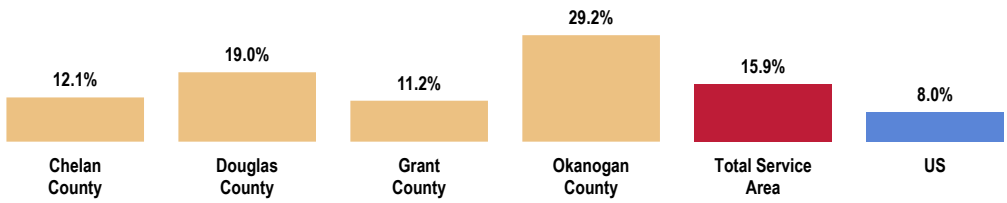


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: • Asked of all respondents.

However, 15.9% of residents characterize local health care services as "fair" or "poor."

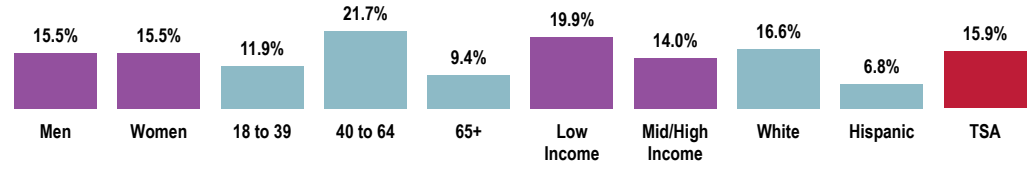
BENCHMARK ► Worse than the national finding.

DISPARITY ► Much higher in Okanogan County. More often reported by adults between the ages of 40 and 64, and non-Hispanic White residents.



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Perceive Local Health Care Services as "Fair/Poor"
(Total Service Area, 2022)

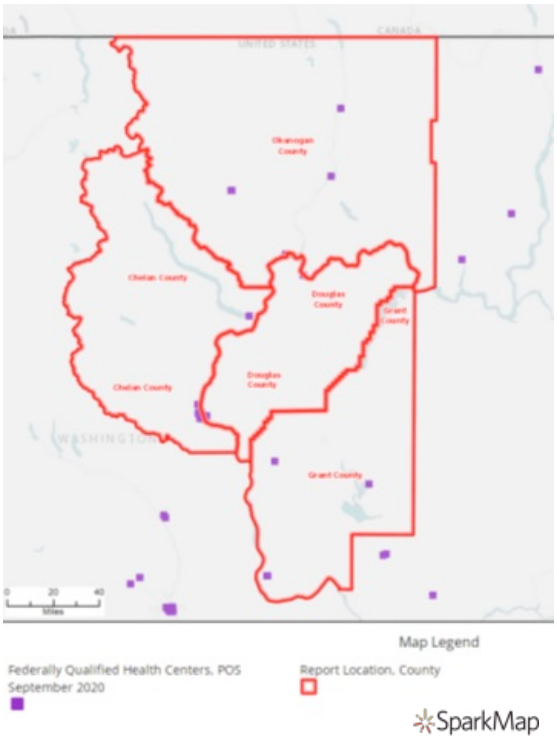


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: • Asked of all respondents.

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

The following map details Federally Qualified Health Centers (FQHCs) within the Total Service Area as of September 2020.



Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Aging and Adult Care of Central Washington
- CAFE
- Columbia Basin Association Clinic
- Columbia Valley Community Health
- Confluence Clinic
- Confluence Health
- Family Health Centers
- Foundation for Youth Resiliency Engagement
- Home and Community Services
- Hospitals
- Link Transit
- Mattawa Community Clinic
- Mid-Valley Medical Group
- Okanogan Behavioral HealthCare
- Okanogan County Community Action Council
- Okanogan County TranGo
- Public Health Clinics
- Samaritan Healthcare
- Samaritan Hospital
- Statewide Health Insurance Benefits Advisors
- Telehealth
- Walk-In Clinic

Cancer

- Cascade Medical Center
- Confluence Clinic
- Confluence Health
- Department of Health Breast, Cervical and Colon Health Program
- Doctor's Offices
- Free Clinic
- Hospitals
- Moses Lake/Quincy Community Health Center
- Samaritan Healthcare

Coronavirus

- Adios COVID
- Agriplex
- Cascade Medical Center
- Cascade School District
- Chelan County Community Health
- Chelan County Fire Districts
- Chelan Douglas Health Department
- Chelan Douglas Health District
- Chelan Valley Hope
- CHI
- Columbia Valley Community Health
- Confluence Health
- Doctor's Offices
- DOH
- EMS
- Family Health Centers
- Health District
- Hospitals
- Lake Chelan Hospital
- Latinos Communications Network
- Mid-Valley Hospital and Clinic
- Okanogan Health District
- Parque Padrinos
- Pharmacies
- Planned Parenthood
- Public Health Department
- Retail Stores
- State Resources
- Vaccination Clinics
- Wenatchee Downtown Association
- Wenatchee Valley Chamber of Commerce

Dementia/Alzheimer's Disease

- Action Health Partners
- Aging and Adult Care of Central Washington
- Alzheimer's Association
- Blossom Valley/Blossom Creek
- Cascade Medical Center
- Confluence Health

- Doctor's Offices
- Hospitals
- Methow Valley at Home
- Mountain Meadows
- Nursing Home
- Okanogan Behavioral HealthCare

Diabetes

- Alternative Healers
- Brewster Fitness Center
- Cascade Medical Center
- Certified Diabetic Educators
- Chelan Douglas Community Action Council
- Chronic Disease Management Programs
- Columbia Basin Hospital
- Confluence Health
- Doctor's Offices
- Family Health Centers
- Fitness Centers/Gyms
- Free Clinic
- Hospitals
- Indian Health Services
- Link Transit
- Mid-Valley Hospital and Clinic
- Moses Lake/Quincy Community Health Center
- North Valley Hospital and Clinic
- Omana
- Parks and Recreation
- Samaritan Healthcare
- School System
- Senior Farmers Market Nutrition Program
- Serve Moses Lake Food Bank
- Upper Valley Mend
- WIC

Disabilities

- Action Health Partners
- Acupuncture
- Aging and Adult Care of Central Washington
- Chiropractors
- Colonial Vista Rehab
- Confluence Health
- Economic Alliance of Okanogan County
- Family Health Centers
- Lilac for the Blind
- Link Transit
- Massage Therapy
- Naturopaths
- Physical and Occupational Therapists
- Wenatchee Valley College
- Worksource
- YMCA

Infant Health and Family Planning

- Columbia Basin Hospital
- Confluence Health
- Family Health Centers
- Family Planning
- Planned Parenthood
- Samaritan Healthcare
- The Maternal Coalition
- WIC
- Women's Resource Center

Heart Disease

- Action Health Partners
- Confluence Health
- Doctor's Offices
- Family Health Centers
- Fitness Centers/Gyms
- Hospitals
- Mended Hearts Support Group
- Moses Lake/Quincy Community Health Center
- Walk-In Clinic

Injury and Violence

- Action Health Partners
- CAFE
- Columbia Valley Community Health
- NAMI
- Okanogan Behavioral HealthCare
- SAGE
- Support Center
- The Center for Drug and Alcohol Treatment
- Together for a Drug Free Youth

Mental Health

- ABHS-Parkside
- Aging and Adult Care of Central Washington
- Behavioral Health Services
- Cascade Medical Center
- Cascade School District
- Catholic Charities

- Catholic Community Services
- Catholic Family Services
- Chelan County Behavioral Health Unit
- Chelan County Regional Justice Center
- Chelan Douglas Alcohol and Drug Treatment Center
- Children's Home Society
- Columbia Counseling
- Columbia Valley Community Health
- Colville Tribe's Behavioral Health Program
- Communities in Schools
- Confluence Health
- Counselors
- Discovery Behavior Solutions
- Diversion
- Doctor's Offices
- DOH
- Family Health Centers
- Foundation for Youth Resiliency Engagement
- FYRE
- Grant County Mental Health
- Heart Springs
- Moses Lake/Quincy Community Health Center
- NAMI
- New Hope
- Okanogan Behavioral HealthCare
- Parkside
- Pateros/Brewster Community Resource Center
- Renew
- Room One
- SAGE
- Samaritan Healthcare
- School System
- State Resources
- Strength of Life
- Support Center
- Susan Dodge, LMHC
- Triple Point
- UV Cares
- Washington Information Network

Nutrition, Physical Activity, and Weight

- Boys and Girls Club
- Columbia Valley Community Health
- Confluence Health
- Cronin's Field House
- CrossFit Four Pillars
- Doctor's Offices
- Family Health Centers
- Farmer's Markets
- Fitness Centers/Gyms
- Food Pantries
- Lauzier Foundation
- Matter of Balance
- North Cascades
- Parks and Recreation
- School System
- SNAP
- Stay Active and Independent for Life
- WIC
- WSU Cooperative Extension
- YMCA

Oral Health

- Children's Dental Village
- Columbia Basin Health Clinic
- Columbia Valley Community Health
- Dentist's Offices
- Doctor's Offices
- Family Health Centers
- Indian Health Services
- Lighthouse
- MEND
- Moses Lake Pediatric Dentistry
- Public Health Department
- SMILE

Respiratory Diseases

- Confluence Health
- Moses Lake/Quincy Community Health Center

Sexual Health

- Family Health Centers
- Foundation for Youth Resiliency Engagement
- Health Care Organizations
- Planned Parenthood
- Room One
- School System

Substance Abuse

- AA/NA
- ABHS-Parkside
- Advance-Recovery Navigator Program

- Cascade Medical Center
- Celebrate Recovery
- Columbia Counseling
- Columbia Valley Community Health
- Confluence Health
- Detox
- Drug and Alcohol Rehab Center
- Family Health Centers
- Foundation for Youth Resiliency Engagement
- Lifeline Ambulance
- Moses Lake/Quincy Community Health Center
- New Hope
- New Path
- Okanogan Behavioral HealthCare
- Recovery Coalition
- Renew
- S.T.O.P
- Samaritan Healthcare
- The Bruce
- The Center
- The Center for Drug and Alcohol Treatment
- Together for a Drug Free Youth

Tobacco Use

- Cascade Medical Center
- Confluence Health
- Family Health Centers
- Okanogan Behavioral HealthCare
- Okanogan County Community Coalition
- Omak TEA Club
- S.T.O.P
- The Center for Drug and Alcohol Treatment
- Together for a Drug Free Youth

APPENDIX

EVALUATION OF PAST ACTIVITIES

Community Benefit

Over the past three years, Confluence Health has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in the $43,964,522 million dollars we provided for charity care and other financial assistance programs over the past 3 years:

- 2021 - $15,474,423
- 2020 - $13,634,827
- 2019 - $14,855,272

Our work also reflects a focus on community health improvement, as described below.

Addressing Significant Health Needs

Confluence Health conducted its last CHNA in 2019 and reviewed the health priorities identified through that assessment. Considering the top-identified needs – as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities – it was determined at that time that Confluence Health (operating Wenatchee Hospital and Central Washington Hospital) would focus on developing and/or supporting strategies and initiatives to improve:

- Chronic Disease: Prevention and Management
- Access to Care: Behavioral Health
- Access to Care: Physical Health
- Substance Use
- Education
- Affordable Housing

Strategies for addressing these needs were outlined in Confluence Health's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Confluence Health (including Wenatchee Valley Hospital and Central Washington Hospital) and its community partners to address these significant health needs in our community. Thank you to all the people and organizations that contributed to these initiatives. These strategies could not be addressed without your support and collaboration.

COVID-19 statement

COVID-19 was an unexpected challenge that could have derailed our initiatives identified in 2019. It continues to be a huge disruption to Confluence Health operations, our personal lives, and our emotional and physical health. In the face of fear, uncertainty and exhaustion, our teams bravely stood up to meet the needs of the communities we serve.

In 2021, Confluence Health led the region in COVID testing, vaccination, community outreach and education. We answered 166,969 phone calls at our COVID Hotline, performed 118,081 tests, and provided 77,288 adult vaccinations and 4,530 pediatric vaccinations. We did this along with caring for people significantly afflicted by the virus. We admitted 830 patients with a primary diagnosis of COVID-19 to inpatient care, with an average length of stay of eight days. Of those patients, 137 required ventilator therapies during their stay.

Employees throughout Confluence Health were asked to help with these efforts, many leaving their usual work undone or covered by others. Having fewer staff was, and continues to be, difficult for inpatient care, clinics, operating rooms, lab, radiology, pharmacy, food services, and every support department. Workflows were modified to meet the needs, and our quality of care was maintained and improved as

shown by our 5-star dashboard, including our long-time goal of hypertension control. All of this was done while remaining extremely busy with increased inpatient days and clinic outpatient visits and keeping a focus on our goals identified in the CHNA.

North Central Accountable Community of Health (NCACH)

NCACH brings together individuals and partners across the region to support regional health priorities that improve the wellbeing of our communities. The mission of the North Central Accountable Community of Health is to advance whole-person health and health equity in North Central Washington by unifying stakeholders, supporting collaboration, and driving systemic change, with particular attention to the social determinants of health.

Their pursuit of equitable system change reflects the aspirations of the entire region, not just the concerns of certain groups or sectors. The NCACH focuses on whole person health, health equity, social determinants of health, behavioral health, and care coordination. Their support is a very valuable asset to the healthcare of our region.

Thank you for assisting in bringing together key partners across North Central Washington to address the 2019 CHNA Initiatives.

Evaluation of Impact

Priority Area: Chronic Disease – Prevention and Management	
Community Health Need	The CDC reports that obesity prevalence in the US is 42.4% (severe obesity prevalence 9.2%). Obesity related preventable conditions include: Heart disease, stroke, type 2 diabetes and some cancers. The residents of NCW identified obesity as the 2nd most important health problem that impacts the community in the 2019 survey.
Goal(s)	• Improve obesity management • Prevent chronic diseases • Reduce morbidity

Strategy 1: Obesity Management	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: Patients with BMI > 28
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital External: North Valley Hospital
Results/Impact	• The Confluence Health Obesity Management Clinic opened September 2021. The clinic brings together physicians who are certified obesity specialists with certified dietitians, behavioral health providers and nurse case managers to provide care to patients. Currently, we are exploring ways to expand clinic services based on demand. • North Valley Hospital created chronic disease management groups and programmatic approaches to focus on diabetes and obesity: As part of their new clinic, they have been able to set up a guided program and are currently working on expanding it to include PT, OT, and Dietitian services as well. Currently, there are 20 patients participating.

Strategy 2: Hypertension Management	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: 18 – 85 years of age
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: N/A
Results/Impact	• Confluence Health utilized AMGA's "Measure Up/Pressure Down" national campaign to focus on improving blood pressure control. • Controlling blood pressure is a corporate goal and is part of our 5-star quality initiative. • In 2021, 62.3% of our patients achieved a blood pressure less than 140/90 mmHg (goal 60%). • Hypertension management remains a corporate goal in 2022.

Strategy 3: Diabetes Care - Blood Sugar Control	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: 18 – 75 years of age
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: Pybus Market Vendors; City of East Wenatchee
Results/Impact	• Controlling blood sugar is a corporate goal and is part of our 5-star quality initiative. • In 2021, 77.5% of our patients achieved an A1C of less than 9% (goal 80%). • Blood sugar control (measured by AC1) and hypertension control have both been named as clinical goals and high priority metrics organization-wide with many of our primary care departments achieving the goals of having 80% of our patients having an HbA1c<9 and over 60% of our patients with good blood pressure (<140/90) • Initiated Diabetes Self-Management Training/Education classes in Wenatchee, Omak and Moses Lake. • Started a Diabetes Prevention Program in Omak • Collaborate with Pybus Market vendors to showcase produce incorporated into Healthy Meals • Working with Eastmont Parks to develop a community kitchen for cooking classes • Our Cardiac and Pulmonary Rehab Programs continue to provide nutrition education • Blood sugar control remains a corporate goal in 2022.

Priority Area: Access to Care – Behavioral Health	
Community Health Need	Not treating mental health conditions can lead to more complicated and severe health problems. The number of available providers in the region is not meeting the needs of our patients and result in access challenges. It takes a community to provide the care that is needed for these patients. The residents of NCW identified behavioral health care as the most important health problem that impacts the community in the 2019 survey.
Goal(s)	• Improve access to care • Eliminate barriers to care • Improve awareness of services

Strategy 1: Expanded Access to Care	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: All
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: North Valley Hospital; Okanogan Behavioral Healthcare

Results/Impact	• Behavioral health visits increased from 36,729 in 2019 to 47,234 in 2021. During that same time, telehealth visits (video and/or phone) grew from 0.75% to 81% of all visits.
	• Added 0.5 FTE inpatient psychiatrist
	• Added 0.5 FTE outpatient psychiatrist
	• The utilization of telehealth in behavior heath care has transformed care and eliminated several barriers. The benefits of telehealth include:
	  ○ Improved access in rural communities
	  ○ Reduced need for transportation
	  ○ Reduced need to pull kids out of school for appointments
	  ○ Results in less lost work hours
	  ○ Provided "safe" form of care during the pandemic
	  ○ Improved patient and provider satisfaction being able to see each other during visits (no masks required)
	• Behavior health providers cared for healthcare works impacted by the stresses of caring for COVID positive patients.
	• In 2021, North Valley Hospital and Okanogan Behavioral Healthcare partnered to allow warm hand-offs from primary care to mental health providers while onsite while eliminating a barrier to follow up care.

Strategy 2: Open Community Behavioral Health Facility	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: 18 years or older (no Medicare insurance)
Partnering Organization(s)	Internal: Confluence Health (interested community partner) External: Parkside Rehabilitation & Care Center

Results/Impact	• Parkside-American Behavioral Health System opened in 2018. This facility expanded care to behavioral health patients by:
	  ○ Appling for and approved as an Evaluation and Treatment Center in June 2021
	  ○ Expanding care to detained patients in the region.
	  ○ Cared for 106 Involuntary Treatment Act patients.
	  ○ Cared for 88 patients requiring 120 hour hold.
	  ○ Provide care for 386 voluntary patients with acute crisis needs.
	  ○ Provided care for patients requiring 14-day detention, 5-day hold, and prevented jail commitments.
	• CH collaborated with Parkside to provide 24 hrs of medication at hospital discharge to remove discharge barrier.
	• CH provides medical care for patients with chronic conditions to remove access barriers.

Strategy 3: Regional Suicide Prevention	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: 18 years old and younger
Partnering Organization(s)	Internal: Confluence Health (program support) External: Suicide Prevention Coalition of North Central Washington; Moment by Moment Suicide Prevention

Results/Impact	• 2019 screened all 9th graders at Wenatchee High School
	• 2020 completed a check-in with all Wenatchee 6th, 7th, 8th graders
	• 2021 began regional implementation of Hope Squad (www.hopesquad.com)
	  ○ Peer-to-peer program to prevent suicide
	  ○ Funding obtained through the North Central Washington ACH
	  ○ Hope Squad will provide support to each school in NCW
	  ○ Curriculum based on wellness and resiliency
	  ○ Addresses inclusion, culture change, mental health, bullying and substance use
	  ○ Create referral partnerships with mental health agencies

Strategy 4: Chelan County Diversion Program	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: All ages
Partnering Organization(s)	Internal: Confluence Health (Emergency Departments), Wenatchee Valley Hospital, Central Washington Hospital External: Chelan County
Results/Impact	• The Diversion Program at Chelan County started September 2021. • The goal is to provide behavioral health support to individuals who have contact with law enforcement or the criminal justice system. • By pairing a mental health professional with a Sheriff Deputy in their car, individuals receive needed behavior health support in real time during active calls in progress. • Sheriff Deputies can refer individuals to the behavioral health professionals during off hours. • The mental health professional follow-up with the reporting party and the individual to support and provide access to services. These services can be referrals to a primary care physician, medication management, housing, transportation, health insurance, income (social security support), food, clothing, substance use treatment and mental health counseling. • The mental health professional is seen as the "social services broker" to law enforcement. • The mental health professional will also do follow up support by calling or meeting with the individual after their initial contact to assist in any further needs and ensure that the individual does not fall through the cracks while navigating services. • The mental health professional will also do a warm hand off when appropriate to other care or treatment providers for further support. • The mental health professional and an assigned Deputy focus some shifts strictly for preventative outreach. • Currently, Chelan County and the Chelan County Sheriff's Office is the only agency that has an embedded mental health professional with law enforcement.

Priority Area: Access to Care - Physical Health	
Community Health Need	Access to medical care is critical to providing safe, high-quality care in a compassionate and cost-effective manner. Many access barriers were identified: long distance travel, high cost of care, staff shortages, primary care and specialty provider shortages, and lack of providers who accept Medicare and Medicaid insurance (i.e. dental care).
Goal(s)	• Improve access to care • Eliminate barriers to care • Improve awareness of services

Strategy #1: Expand Providers and Services	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: All ages
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: People for People; North Valley Hospital, Upper Valley Mend
Results/Impact	• Our first pediatric cardiologist was hired in 2020 to expand pediatric cardiac services. • Pediatric Gender Affirming Care Guidelines for transgender and gender diverse youth were approved in August of 2021 and is being offered to the community. • In 2021, CH began a home infusion nursing therapy (HINT) program expanding medication infusions to be completed in patients' homes throughout the region as an alternative to infusion center administration. This service receives high satisfaction with patients, staff, and providers. Currently working to scale up this program. • In 2019 hired an RN case manager and implemented the Maternity Support Services (MSS) program, available through the Health Care Authority, to improve birth outcomes and the health of newborns. MSS is focused on delivering preventative health, education services, and brief interventions to eligible pregnant clients and newborns during their first year. This program is integrated inside the clinic. Patients are screened and referred to services in the community to include nutrition, behavioral health and alcohol and drug treatment programs. • In 2021 expanded our prenatal and postnatal care by adding lactation consultation services in the outpatient setting. This service provides patients an International Board-Certified Lactation Consultant RN sixteen hours each week to assist with breastfeeding concerns and education. Integrating this service prenatally allows patients to have more success post birth with latching and feeding and reduces medical costs for mother and child and assists in providing long-term health of babies. • As a result of COVID, an organization-wide telehealth program was implemented in early 2020. The program was implemented over a 10-day period and continues to be utilized across the organization. • Expanded special care nursery (SCN) care to 32-week newborns (down from 36 weeks). • Integrated a clinical pharmacist within the cardiology dept. The pharmacist has been able to improve clinical outcomes in patients with cardiac conditions. • North Valley Hospital: Opened Tonasket Medical Clinic to provide primary care in an underserved area in 2019. • People for People: Offer transportation services in Adams, Grant, and Lincoln counties. Most fixed-route stops are at medical facilities. • Upper Valley Mend: Expanded Upper Valley Free Clinic program to include dental services (dentures, fillings, extractions) as well as financial assistance for medical bills.

Strategy # 2: COVID Testing and Vaccination	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: All eligible ages
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: Chelan-Douglas Health District, Teresita's Consulting

Results/Impact	• Provided access to vaccine and testing sites for the communities of North Central Washington.
	• 65,000 doses were procured, transported, and prepared for administration for the health district's vaccine site.
	• Research: 2 inpatient trials and 1 outpatient trial related to Covid-19
	  ○ Inpatient trials brought care to patients with limited options that would not have been available in the valley otherwise
	  ○ Outpatient trial was the Pfizer Covid vaccine trial. We were able to ensure members of community were vaccinated early and part of the groundbreaking research that brought that therapy to the masses
	• Total vaccines administered: 81,818
	• Total COVID tests administered: 118, 081
	• Partnered with the Latinx community to improve care related to COVID
	  ○ Latino Center for Health identified four counties in the state with the highest vaccination rates (San Juan 76%, ***Okanogan 76%, Douglas 63.7%, and Chelan 59.3%***)
	  ○ Awarded a HRSA grant for $544,819 to work on health equity initiatives

Strategy # 3: Telehealth Expansion	
Strategy Was Implemented?	Yes
Target Population(s)	Ages: All
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: N/A

Results/Impact	• Developed virtual Annual Wellness visits and chronic care management via telehealth increasing access in our rural areas.
	• As a result of COVID, an organization-wide telehealth program was implemented in early 2020. The program was implemented over a 10-day period and continues to be utilized across the organization.
	• Total telehealth visits by year:
	  ○ 2019: 1,257 visits
	  ○ 2020: 126,523 visits
	  ○ 2021: 95,568 visits

Priority Area: Substance Use	
Community Health Need	Increased prescribing of prescription opioids over the last 20+ years has contributed to the opioid epidemic that is sweeping the United States and North Central Washington. It is a recognized need in the community to reduce the number of patients with severe opioid use disorder and prevent overdose deaths from prescription drugs.
Goal(s)	• Decrease opioid prescribing • Expand safety network • Decrease alcohol use • Decrease illicit drug use

Strategy # 1: Opioid Workgroups Established	
Strategy Was Implemented?	Yes
Target Population(s)	Age: All patients with opioid prescriptions
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: North Central Washington ACH, Together for Youth, Fyre
Results/Impact	Confluence Health established an Opioid Epidemic Response Team to focus changing opioid prescribing: • Reduced combination opioid/benzo prescribing down to 113 patients • Reduced the number of patients on >90 MME/day down to 448 patients • Quarter 3, 2021, reduced the total number of opioid prescriptions to 19,870 • Developing standard on-boarding education for providers entering health system North Central Washington ACH has developed a regional opioid workgroup to support the sharing of resources and expanding opioid and recovery related services for clinical and non-clinical partners in our area. • Supports school-based prevention efforts • Initiated a jail pilot program at the Chelan County Regional Justice Center to provide a recovery coach for individuals upon release from incarceration. Plan to expand to Grant County Jail in 2022. • Expanded Recovery Coaches in North Central Washington through CCAR Recovery Coach training.

Strategy # 2: Medication Take Back Boxes	
Strategy Was Implemented?	Yes
Target Population(s)	Age: All
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: North Valley Hospital, North Central Washington ACH
Results/Impact	• After partnering with local health care organizations and retail pharmacies to implement medication take back boxes across the four counties in 2017, Confluence Health successfully transitioned all medication take-back boxes to the state funded program across the 4-county region. • North Valley Hospital created a Drug Disposal Kiosk Program: This program was originally funded in part by the NCACH as an Opioid Grant Project. The program included the installation of the Drug Disposal Kiosk in the hospital lobby working with a vendor for disposal called The American RX, as well as patient and provider education. The kiosk was advertised through external channels and with a partnership with the Tonasket School District.

Strategy # 3: Expand Access to Naloxone	
Strategy Was Implemented?	Yes
Target Population(s)	Age: Patients and families at risk of experiencing an opioid overdose
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: North Central Washington ACH
Results/Impact	• CH implemented a naloxone dispensing program in the ER to improve access when treating patients with acute opioid overdose. • Confluence Health prescribers increased the number of patients co-prescribed naloxone to 51% • Implemented Naloxone (Narcan) vending machines in Moses Lake and Wenatchee (900 doses ordered for the vending machines). Narcan Vending Machines Stationed in Wenatchee & Moses Lake – NewsRadio 560 KPQ • ACH: distributed 800 doses of naloxone

Priority Area: Education	
Community Health Need	Patient education promotes patient-centered care and increases adherence to medications and treatments. This can translate into more efficient and cost-effective healthcare delivery. In addition, education leads to better jobs and higher income. Research shows that better educated individuals live longer, healthier lives.
Goal(s)	• Increase graduation rates • Develop career opportunities • Improve health literacy

Strategy # 1: COVID Hispanic Partnership	
Strategy Was Implemented?	Yes
Target Population(s)	Latino populations in our region, including migrant workers
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: Parque Padrinos, CAFÉ, Teresita's Consulting
Results/Impact	• Throughout the pandemic, Dr. Mabel Bodell has been a strong advocate for the Spanish-speaking communities in North Central Washington. See this video link: https://youtu.be/hZaZIQSQx5M • Confluence Health partnered with Parque Padrinos to advance vaccine uptake in the Latinx community.

Strategy # 2: Career Advancement	
Strategy Was Implemented?	Yes
Target Population(s)	18 yo and older
Partnering Organization(s)	Internal: Confluence Health, Wenatchee Valley Hospital, Central Washington Hospital External: WA Association for Community Health, Wenatchee Valley College

Results/Impact	• Collaboration with WA Association for Community Health
	  ○ Initiated a medical assistant (MA) Apprentice Program at CH in collaboration with the WA Association for Community Health that provides an avenue of training and education for staff to be able to continue to work full-time and advance their learning, training, and credentials through education.
	  ○ 13 apprentices enrolled in this program and looking to enroll 2 more each year for the next few years.
	• Collaboration with Wenatchee Valley College (WVC)
	  ○ Partnered with WVC to create a Pharmacy Technician training program at the college.
	  ○ Committed to financially support the cost of the Pharmacy Technician Program Director

Priority Area: Affordable Housing	
Community Health Need	The costs of living in this valley will force residents to choose between housing and taking care of their other basic needs. Our homeless population is growing, and we have a housing shortage. The cost of housing is exceeding the income of many critical healthcare workers in North Central Washington, and it is becoming a barrier to recruitment.
Goal(s)	• Understand the impact of homelessness on our healthcare system. • Improve quality of life • Create stability

Strategy # 1: Low Barrier Homeless Shelter	
Strategy Was Implemented?	Yes
Target Population(s)	Homeless Population
Partnering Organization(s)	Internal: Confluence Health (interested party) External: City of Wenatchee, City of East Wenatchee
Results/Impact	• East Wenatchee City Council approved one-tenth of 1% sales and use tax in March 2021. Tax will generate $800,000 to $900,000 annually. • Wenatchee City Council approved one-tenth of 1% sales and use tax in March 2021. Tax will generate $400,000 annually. • Columbia River Local Homeless Housing Task Force established as a joint effort between the cities of Wenatchee and East Wenatchee. • showpublisheddocument (wenatcheewa.gov)

Strategy # 2: The Intersection Between Homelessness & Health	
Strategy Was Implemented?	Yes
Target Population(s)	Homeless Population
Partnering Organization(s)	Internal: Confluence Health External: Confluence Health Foundation

Results/Impact	• Confluence Health Foundation conducted study comparing the cost of admission for homeless patients vs. non-homeless patients.
	• CH Foundation funded the publishing of the results and community recommendations.
	• Findings:
	  ○ 350 people identified as homeless, a decrease of about 15% from the previous year; about one-quarter are unsheltered and live on the streets.
	  ○ 43 people identified as chronically homeless, which is about 19% more than last year. An individual is considered chronically homeless if they have been homeless for a period of at least a year and they have a disability.
	  ○ Locally, the most frequent self-reported reasons for homelessness include disability, behavioral health conditions, and chronic health conditions, echoing the strong relationship between health and homelessness described above.
	  ○ Homelessness is a barrier for discharge and patient placement
	  ○ Average loss per patient per year = $3502
	• After discussions with two long term care facilities were initiated to secure homeless patient beds for medical respite, it was determined to be cost prohibitive. Alternatives need to be identified.